

**LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT**

**Volume XXV
102nd Congress
1991-1992**



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Legislative History of Titles I-XX of the Social Security Act

**Volume XXV
102nd Congress
1991-1992**

**Compiled by the
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PREFACE

This legislative history has been prepared to provide a convenient reference source for studies of the development of the provisions of the Social Security Act as amended by the 102nd Congress.

The legislative history began with the Social Security Act, as enacted on August 14, 1935, and pertained only to the benefit programs (titles II, XVI, and XVIII) administered by the Social Security Administration. Beginning with the legislative history of the 95th Congress, the history has been expanded to include the 20 titles of the Social Security Act.

This legislative history includes:

Every enactment of the 102nd Congress
amending the Social Security Act.

Relevant Committee Reports of the House of
Representatives and the Senate relating to
the Social Security Act together with the
Conference Reports.

Excerpts were substituted for the full text where pertinent.

In some instances a report accompanying a public law will not reflect a particular amendment to the Social Security Act because the amendment was added to the bill on the floor of the House or Senate after the issuance of the report, or the subject matter involved was not included in the report of the committee proceedings. In these cases, background material relating to the amendment may be found in the Congressional Record report of the House or Senate debate on the bill. The Congressional Record may also provide a useful supplemental reference source even in those cases in which the House or Senate report discusses the particular provision in which the researcher is interested. It is not feasible to reproduce in this legislative history the thousands of pages of the Congressional Record carrying the House and Senate debates with respect to the public laws included in this history. However, the volume number of the Congressional Record and the listing of the dates on which the public law was considered in the House and Senate appear on the last page of each public law.

The material included in this
legislative history is an
exact photo-reproduction of
the original documents.

Finder's Aid
P.L. 102-54 (105 Stat. 267) Approved June 13, 1991
Amendments to Title 38, United States Code

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>105 Stat.</u>
Old-Age and Survivors Survivors Insurance Benefit Payments	202 (t) (4) (D)	13 (q) (3) (C) (i)	279
Old-Age and Survivors Insurance Benefit Payments	202 (t) (4) (D)	13 (q) (3) (C) (ii)	279
Benefits in Case of Veterans	217 (a) (1) (B)	13 (q) (3) (A) (i)	279
Benefits in Case of Veterans	217 (b) (1)	13 (q) (3) (D)	279
Benefits in Case of Veterans	217 (b) (2)	13 (q) (3) (E) (i) (I)	279
Benefits in Case of Veterans	217 (b) (2)	13 (q) (3) (E) (i) (II)	279
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Benefits in Case of Veterans	217 (b) (2)	13 (q) (3) (E) (v)	279
Benefits in Case of Veterans	217 (e) (1) (B)	13 (q) (3) (A) (i)	279
Benefits at Age 72 - Veterans	228 (h) (2)	13 (q) (3) (B) (i)	279

P.L. 102-54

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>105 Stat.</u>
Child Support and Establishment of Paternity - Definitions	462 (f) (2)	13 (q) (3) (B) (ii)	279
General Provisions	1128 (b) (5) (A)	13 (q) (3) (A) (ii)	279
General Provisions	1133 (a) (1)	13 (q) (3) (B) (iii)	279
Hospital Insurance Benefits for the Aged and Disabled	1814 (h) Heading	13 (q) (3) (A) (iv)	279
Hospital Insurance Benefits for the Aged and Disabled	1814 (h) (1)	13 (q) (3) (A) (iii)	279
Hospital Insurance Benefits for the Aged and Disabled	1814 (h) (2)	13 (q) (3) (B) (iv)	279
Health Insurance for the Aged and Disabled	1866 (a) (1) (h)	13 (q) (3) (F)	280
Grants to States for Medical Assistance Programs	1928 (a) (5) (F)	13 (q) (3) (A) (v)	279

Public Law 102-54
102d Congress

An Act

To amend title 38, United States Code, with respect to veterans programs for housing and memorial affairs, and for other purposes.

June 13, 1991
[H.R. 232]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. NOTIFICATION REQUIREMENT.

Section 1832(a)(4) of title 38, United States Code, is amended by striking out subparagraph (C).

SEC. 2. PROPERTY MANAGEMENT.

(a) **VENDEE LOANS.**—Section 1833(a) of title 38, United States Code, is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following:

“(2) After September 30, 1990, the percentage limitations described in paragraph (1) of this subsection shall have no effect.

“(3) The Secretary may, beginning on October 1, 1990, sell any note evidencing a loan referred to in paragraph (1)—

“(A) with recourse; or

“(B) without recourse, but only if the amount received is equal to an amount which is not less than the unpaid balance of such loan.”.

(b) **REPEAL OF TERMINATION DATE.**—Section 1833(a) of such title is amended—

(1) by striking out paragraph (6); and

(2) by redesignating paragraph (7) as paragraph (6).

SEC. 3. EXTENSIONS OF PROVISIONS RELATING TO DEFAULT PROCEDURES AND APPRAISALS.

(a) **DEFAULT PROCEDURES.**—Section 1832(c)(11) of title 38, United States Code, is amended by striking out “October 1, 1991” and inserting in lieu thereof “December 31, 1992”.

(b) **APPRAISALS.**—Section 1831(f)(3) of such title is amended by striking out “October 1, 1990” and inserting in lieu thereof “December 31, 1992”.

(c) **REPORT RELATING TO APPRAISAL REVIEW.**—Section 1831(f) of such title is further amended by adding at the end the following new paragraphs:

“(4) Not later than April 30 of each year following a year in which the Secretary authorizes lenders to determine reasonable value of property under this subsection, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report relating to the exercise of that authority during the year in which the authority was exercised.

“(5) A report submitted pursuant to paragraph (4) of this subsection shall include, for the period covered by each report—

“(A) the number and value of loans made by lenders exercising the authority of this subsection;

(D) Subsection (a)(2)(B) of section 314 (42 U.S.C. 246) is amended—

(i) by striking out “Veterans’ Administration” and inserting in lieu thereof “Department of Veterans Affairs”;

(ii) by striking out “Administrator of Veterans’ Affairs” and inserting in lieu thereof “Secretary of Veterans Affairs”; and

(iii) by striking out “such Administration” and inserting in lieu thereof “such Department”.

(E) Section 485 (42 U.S.C. 287c-2) is amended by striking out “Chief Nursing Officer of the Veterans’ Administration” in subsection (b)(2)(A) and inserting in lieu thereof “chief nursing officer of the Department of Veterans Affairs”.

(2) SAFE DRINKING WATER ACT AMENDMENTS OF 1986.—Section 109(c) of the Safe Drinking Water Act Amendments of 1986 (42 U.S.C. 300g-6 note) is amended by striking out “the Administrator of the Veterans’ Administration” and inserting in lieu thereof “the Secretary of Veterans Affairs”.

(3) SOCIAL SECURITY ACT.—The Social Security Act (42 U.S.C. 301 et seq.) is amended as follows:

(A) The following provisions are amended by striking out “Veterans’ Administration” and inserting in lieu thereof “Department of Veterans Affairs”:

(i) Subsections (a)(1)(B) and (e)(1)(B) of section 217 (42 U.S.C. 417).

(ii) Subsection (b)(5)(A) of section 1128 (42 U.S.C. 1320a-7).

(iii) Subsection (h)(1) of section 1814 (42 U.S.C. 1395f).

(iv) The heading of subsection (h) of section 1814.

(v) Subsection (a)(5)(F) of section 1928 (42 U.S.C. 1396s).

(B) The following provisions are amended by striking out “Veterans’ Administration” each place it appears and inserting in lieu thereof “Secretary of Veterans Affairs”:

(i) Subsection (h)(2) of section 228 (42 U.S.C. 428).

(ii) Subsection (f)(2) of section 462 (42 U.S.C. 662).

(iii) Subsection (a)(1) of section 1133 (42 U.S.C. 1320b-3).

(iv) Subsection (h)(2) of section 1814 (42 U.S.C. 1395f).

(C) Subparagraph (D) of section 202(t)(4) (42 U.S.C. 402(t)(4)) is amended—

(i) by striking out “Administrator of Veterans’ Affairs” and inserting in lieu thereof “Secretary of Veterans Affairs”; and

(ii) by striking out “if the Administrator” both places it appears and inserting in lieu thereof “Secretary of Veterans Affairs”.

(D) Subsection (b)(1) of section 217 (42 U.S.C. 417) is amended by striking out “Veterans’ Administration to be payable by it” and inserting in lieu thereof “Secretary of Veterans Affairs to be payable by him”.

(E) Subsection (b)(2) of section 217 (42 U.S.C. 417) is amended—

(i) in the first sentence—

(I) by striking out “Veterans’ Administration” the first place it appears and inserting in lieu thereof “Secretary of Veterans Affairs”; and

(II) by striking out “the Veterans’ Administration” the second place it appears and inserting in lieu thereof “that Secretary”;

(ii) in the second sentence, by striking out “Veterans’ Administration” and inserting in lieu thereof “Secretary of Veterans Affairs”;

(iii) in the third sentence—

(I) by striking out “If the Veterans’ Administration” and inserting in lieu thereof “If the Secretary of Veterans Affairs”; and

(II) by striking out “it shall” and inserting in lieu thereof “the Secretary of Veterans Affairs shall”;

(iv) in the fourth sentence—

(I) by striking out “Veterans’ Administration” and inserting in lieu thereof “Secretary of Veterans Affairs”; and

(II) by striking out “such Administration” and inserting in lieu thereof “that Secretary”; and

(v) in the fifth sentence, by striking out “Veterans’ Administration” and inserting in lieu thereof “Secretary of Veterans Affairs”.

(F) Subsection (a)(1)(L) of section 1866 (42 U.S.C. 1395cc) is amended by striking out “Administrator of Veterans’ Affairs” and inserting in lieu thereof “Secretary of Veterans Affairs”.

(4) OMNIBUS RECONCILIATION ACT OF 1980.—Section 966 of the Omnibus Reconciliation Act of 1980 (42 U.S.C. 632a) is amended—

(A) in subsection (c)(6)—

(i) by striking out “Veterans’ Administration” both places it appears and inserting in lieu thereof “Department of Veterans Affairs”; and

(ii) by striking out “Administrator of Veterans’ Affairs” and inserting in lieu thereof “Secretary of Veterans Affairs”; and

(B) in subsection (e)(1), by striking out “Veterans’ Administration” and inserting in lieu thereof “Secretary of Veterans Affairs”.

(5) HOUSING ACT OF 1949.—Section 535 of the Housing Act of 1949 (42 U.S.C. 1490o) is amended—

(A) in subsections (a) and (b), by striking out “Administrator of Veterans’ Affairs” and inserting in lieu thereof “Secretary of Veterans Affairs”, and

(B) in subsection (c), by striking out “Veterans’ Administration” and inserting in lieu thereof “Department of Veterans Affairs”.

(6) LANHAM PUBLIC WAR HOUSING ACT.—The Act of October 14, 1940 (42 U.S.C. 1501 et seq.), popularly known as the “Lanham Public War Housing Act”, is amended as follows:

(A) Section 601 (42 U.S.C. 1581) is amended by striking out “Veterans’ Administration” each place it appears in subsection (d)(1) and inserting in lieu thereof “Secretary of Veterans Affairs”.

(A) by striking out “approved” in the first sentence and inserting in lieu thereof “appraised”; and

(B) by striking out “approval” in the second and inserting in lieu thereof “appraisal”).

(2) Section 1825(c) is amended—

(A) in paragraph (2), by striking out “There” and inserting in lieu thereof “Except as provided in paragraph (3) of this subsection, there”; and

(B) by adding at the end the following new paragraph:

“(3) In the case of a loan described in clause (C) of section 1829(a)(2) of this title, there shall be credited to the Guaranty and Indemnity Fund, in lieu of any amount that would otherwise be credited for such a loan under subparagraph (A) or (B) of paragraph (2) of this subsection—

“(A) for each loan closed during fiscal year 1990, an amount equal to 0.25 percent of the original amount of the loan for each of the fiscal years 1991 and 1992;

“(B) for each loan closed after fiscal year 1990, an amount equal to 0.25 percent of the original amount of the loan for the fiscal year in which the loan is closed and for the following fiscal year.”.

(3) Section 1829(a) is amended by striking out paragraphs (3) and (4) and redesignating paragraph (5) as paragraph (3).

(4) Section 1829(c)(2) is amended by striking out “section 1825(c)(2) (A) or (B) of this title and subsection (a)(3) of this section” and inserting in lieu thereof “clause (A) or (B) of paragraph (2) of section 1825(c) of this title or paragraph (3) of that section”.

(5) Section 1833 is amended by striking out the subsection (e) that was added by section 5003(a) of Public Law 101-239.

(b) RATIFICATION.—(1) Any action of the Secretary of Veterans Affairs or the Secretary of the Treasury—

(A) that was taken during the period beginning on October 1, 1990, and ending on the date of the enactment of this Act; and

(B) that would have been an action carried out under section 1825(c)(3) of title 38, United States Code, if the amendment made by paragraph (2) of subsection (a) of this section had been made before October 1, 1990,

is hereby ratified.

(2) Any failure to act by the Secretary of Veterans Affairs or the Secretary of the Treasury during such period under section 1829(a)(3) of such title is hereby ratified.

Approved June 13, 1991.

38 USC 1825
note.

LEGISLATIVE HISTORY—H.R. 232:

CONGRESSIONAL RECORD, Vol. 137 (1991):

Feb. 6, considered and passed House.

May 16, considered and passed Senate, amended.

May 22, House concurred in Senate amendments.

Finder's Aid
P.L. 102-107 (105 Stat. 541) Approved August 17, 1991
Emergency Unemployment Compensation Act of 1991

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>105 Stat.</u>	<u>H. Rep. 102-184</u>
Advisory Council on Unemployment Compensation	908	9	547	11, 16-18

Public Law 102-107
102d Congress

An Act

To provide emergency unemployment compensation, and for other purposes.

Aug. 17, 1991

[H.R. 3201]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Emergency Unemployment Compensation Act of 1991".

SEC. 2. FEDERAL-STATE AGREEMENTS.

(a) **IN GENERAL.**—Any State which desires to do so may enter into and participate in an agreement under this Act with the Secretary of Labor (hereafter in this Act referred to as the "Secretary"). Any State which is a party to an agreement under this Act may, upon providing 30 days written notice to the Secretary, terminate such agreement.

(b) **PROVISIONS OF AGREEMENT.**—Any agreement under subsection (a) shall provide that the State agency of the State will make payments of emergency unemployment compensation—

(1) to individuals who—

(A) have exhausted all rights to regular compensation under the State law;

(B) have no rights to compensation (including both regular compensation and extended compensation) with respect to a week under such law or any other State unemployment compensation law or to compensation under any other Federal law (and are not paid or entitled to be paid any additional compensation under any State or Federal law); and

(C) are not receiving compensation with respect to such week under the unemployment compensation law of Canada; and

(2) for any week of unemployment which begins in the individual's period of eligibility (as defined in section 7(2)).

(c) **EXHAUSTION OF BENEFITS.**—For purposes of subsection (b)(1)(A), an individual shall be deemed to have exhausted such individual's rights to regular compensation under a State law when—

(1) no payments of regular compensation can be made under such law because such individual has received all regular compensation available to such individual based on employment or wages during such individual's base period; or

(2) such individual's rights to such compensation have been terminated by reason of the expiration of the benefit year with respect to which such rights existed.

(d) **WEEKLY BENEFIT AMOUNT.**—For purposes of any agreement under this Act—

(1) the amount of emergency unemployment compensation which shall be payable to any individual for any week of total unemployment shall be equal to the amount of the regular

Emergency
Unemployment
Compensation
Act of 1991.

Inter-
governmental
relations.

26 USC 3304
note.

26 USC 3304
note.

SEC. 9. ADVISORY COUNCIL ON UNEMPLOYMENT COMPENSATION.

26 USC 3304
note.
42 USC 1108.

Section 908 of the Social Security Act is amended to read as follows:

“ADVISORY COUNCIL ON UNEMPLOYMENT COMPENSATION

“SEC. 908. (a) ESTABLISHMENT.—Not later than February 1, 1992, and every 4th year thereafter (but not before February 1 of such 4th year), the Secretary of Labor shall establish an advisory council to be known as the Advisory Council on Unemployment Compensation (referred to in this section as the ‘Council’).

“(b) FUNCTION.—It shall be the function of each Council to evaluate the unemployment compensation program, including the purpose, goals, countercyclical effectiveness, coverage, benefit adequacy, trust fund solvency, funding of State administrative costs, administrative efficiency, and any other aspects of the program and to make recommendations for improvement.

“(c) MEMBERS.—

“(1) IN GENERAL.—Each Council shall consist of 11 members as follows:

“(A) 5 members appointed by the President, to include representatives of business, labor, State government, and the public.

“(B) 3 members appointed by the President pro tempore of the Senate, in consultation with the Chairman and ranking member of the Committee on Finance.

“(C) 3 members appointed by the Speaker of the House, in consultation with the Chairman and ranking member of the Committee on Ways and Means.

“(2) QUALIFICATIONS.—In appointing members under subparagraphs (B) and (C), the President pro tempore of the Senate and the Speaker of the House shall each appoint—

“(A) 1 representative of the interests of business,

“(B) 1 representative of the interests of labor, and

“(C) 1 representative of the interests of State governments.

“(3) VACANCIES.—A vacancy in any Council shall be filled in the manner in which the original appointment was made.

“(4) CHAIRMAN.—The President shall appoint the Chairman.

President.

“(d) STAFF AND OTHER ASSISTANCE.—

“(1) IN GENERAL.—Each council may engage any technical assistance (including actuarial services) required by the Council to carry out its functions under this section.

“(2) ASSISTANCE FROM SECRETARY OF LABOR.—The Secretary of Labor shall provide each Council with any staff, office facilities, and other assistance, and any data prepared by the Department of Labor, required by the Council to carry out its functions under this section.

“(e) COMPENSATION.—Each member of any Council—

“(1) shall be entitled to receive compensation at the rate of pay for level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the actual performance of duties vested in the Council, and

“(2) while engaged in the performance of such duties away from such member's home or regular place of business, shall be allowed travel expenses (including per diem in lieu of subsist-

ence) as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

“(f) REPORT.—

“(1) IN GENERAL.—Not later than February 1 of the second year following the year in which any Council is required to be established under subsection (a), the Council shall submit to the President and the Congress a report setting forth the findings and recommendations of the Council as a result of its evaluation of the unemployment compensation program under this section.

“(2) REPORT OF FIRST COUNCIL.—The Council shall include in its February 1, 1994, report findings and recommendations with respect to determining eligibility for extended unemployment benefits on the basis of unemployment statistics for regions, States, or subdivisions of States.”.

26 USC 3304
note.

SEC. 10. EMERGENCY DESIGNATION.

(a) EMERGENCY DESIGNATION.—Pursuant to sections 251(b)(2)(D)(i) and 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985, the Congress hereby designates all direct spending amounts provided by this Act (for all fiscal years) and all appropriations authorized by this Act (for all fiscal years) as emergency requirements within the meaning of part C of the Balanced Budget and Emergency Deficit Control Act of 1985.

(b) EFFECTIVENESS.—Notwithstanding any other provision of law or any other provision of this Act, none of the preceding sections of this Act shall take effect unless, not later than the date of the enactment of this Act, the President submits to the Congress a written designation of all direct spending amounts provided by this Act (for all fiscal years) and all appropriations authorized by this Act (for all fiscal years) as emergency requirements within the meaning of part C of the Balanced Budget and Emergency Deficit Control Act of 1985.

Approved August 17, 1991.

LEGISLATIVE HISTORY—H.R. 3201:

HOUSE REPORTS: No. 102-184 (Comm. on Ways and Means).

CONGRESSIONAL RECORD, Vol. 137 (1991):

Aug. 2, considered and passed House and Senate.

EMERGENCY UNEMPLOYMENT COMPENSATION ACT OF 1991

AUGUST 2, 1991.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 3201]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3201) to provide emergency unemployment compensation, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. INTRODUCTION

A. PURPOSE AND SCOPE OF THE BILL

The Committee on Ways and Means completed action on H.R. 3201 on August 2, 1991. The purposes of the bill are: (1) to make extensions of benefits to long-term unemployed workers more widely available; (2) to restore unemployment insurance for ex-servicemembers to the same levels civilians receive; and (3) to establish an advisory council on unemployment insurance.

B. BACKGROUND AND NEED FOR LEGISLATION

During the last economic cycle, the economy reached its peak around June 1990 when the seasonally adjusted civilian unemployment rate bottomed out at 5.3 percent. Since the recession began, the civilian unemployment rate has risen almost steadily to 7.0 percent in June 1991. Today, if the unemployment rate were 5.3 percent again, nearly 2 million more workers would be employed. Total unemployment in June stood at 8.7 million workers, and

ing period. In addition, reservists must serve 180 continuous days on active duty to receive credit for their service.

Explanation of provision

This provision would make a permanent change to provide unemployment benefits for ex-servicemembers' on the same basis as benefits are provided to unemployed civilians. Unemployed veterans of Operation Desert Storm and other ex-servicemembers would have a waiting period of no more than one week and would be eligible for a full 26 weeks of regular benefits (versus a 4 week wait and only 13 weeks of regular benefits under current law). In addition, reserve members who have been called to active duty could receive benefits after serving a continuous period of 90 days, instead of having to meet the current 180 day requirement.

III. ADVISORY COUNCIL

Present law

Title IX of the Social Security Act requires the Secretary of Labor to establish a Federal Advisory Council on unemployment compensation. The number of members must not exceed 16, including the chairman. The Council's purpose is to review the Federal-State unemployment compensation system and to make recommendations for change to the Secretary.

The Council is appointed by the Secretary, and members must consist of representatives of employers and employees, in equal numbers, and the public. The Council held its last formal meeting on April 22 and 23 of 1981. Its charter expired in 1986.

Explanation of provision

This provision would provide for the establishment of an Unemployment Compensation Advisory Council. The Council would be similar in function to the Social Security Advisory Council. It would be appointed every four years to examine the purpose, goals and functioning of the unemployment compensation system, and to make recommendations for improvement. Five of the members would be appointed by the President, 3 by the Speaker of the House in consultation with the Chairman of the Committee on Ways and Means, and 3 by the President pro tempore of the Senate in consultation with the Chairman of the Committee on Finance.

IV. BUDGET COMPLIANCE

Present law

The Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Enforcement Act of 1990, provides for a way to exempt new outlays from spending caps and the pay-as-you-go sequester by designating them as an emergency.

The Balanced Budget and Emergency Deficit Control Act of 1985, as amended, provides for losses in revenue or increases in mandatory spending are not offset by some combination of increases in revenue or cuts in other mandatory spending, a sequester of non-exempt mandatory spending will occur 15 days after Congress adjourns for the year. Under the sequester, cuts are imposed on all

On February 20, 1991, the Subcommittee held a hearing on Coverage and Finance Issues in the Unemployment Insurance System (Serial 102-7).

On February 26, 1991, the Subcommittee held a hearing on Long-Term Unemployed (Serial 102-2).

On February 28, 1991, the Subcommittee held a hearing on Job Search and Re-employment Services for the Unemployed (Serial 102-9).

C. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to this Committee by the Committee on Government Operations with respect to the provisions contained in this bill.

D. INFLATION IMPACT

In compliance with clause 2(1)(4)(B) of rule XI of the Rules of the House of Representatives, the Committee states that the provisions of the amendments are not expected to have any inflationary impact on the economy.

V. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 8521 OF TITLE 5, UNITED STATES CODE

§ 8521. Definitions; application

(a) For the purpose of this subchapter—

(1) "Federal service" means active service (not including active duty in a reserve status unless for a continuous period of [180] 90 days or more) in the armed forces or the Commissioned Corps of the National Oceanic and Atmospheric Administration if with respect to that service—

(A) * * *

* * * * *

[(c)(1) An individual shall not be entitled to compensation under this subchapter for any week before the fifth week beginning after the week in which the individual was discharged or released.

[(2) The aggregate amount of compensation payable on the basis of Federal service (as defined in subsection (a)) to any individual with respect to any benefit year shall not exceed 13 times the individual's weekly benefit amount for total unemployment.]

SOCIAL SECURITY ACT

* * * * *

[FEDERAL ADVISORY COUNCIL

【SEC. 908. (a) The Secretary of Labor shall establish a Federal Advisory Council, of not to exceed 16 members including the chairman, for the purpose of reviewing the Federal-State program of unemployment compensation and making recommendations to him for improvement of the system.

【(b) The Council shall be appointed by the Secretary without regard to the civil service laws and shall consist of men and women who shall be representatives of employers and employees in equal numbers and the public.

【(c) The Secretary may make available to the Council an Executive Secretary and secretarial, clerical, and other assistance, and such pertinent data prepared by the Department of Labor, as it may require to carry out its functions.

【(d) Members of the Council shall, while serving on business of the Council, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by 5 U.S.C. 5703 for persons in government service employed intermittently.

【(e) The Secretary shall encourage the organization of similar State advisory councils.

【(f) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed \$100,000, as may be necessary to carry out the purposes of this section.】

ADVISORY COUNCIL ON UNEMPLOYMENT COMPENSATION

SEC. 908. (a) ESTABLISHMENT.—Not later than February 1, 1992, and every 4th year thereafter (but not before February 1 of such 4th year), the Secretary of Labor shall establish an advisory council to be known as the Advisory Council on Unemployment Compensation (referred to in this section as the "Council").

(b) FUNCTION.—It shall be the function of each Council to evaluate the unemployment compensation program, including the purpose, goals, countercyclical effectiveness, coverage, benefit adequacy, trust fund solvency, funding of State administrative costs, administrative efficiency, and any other aspects of the program and to make recommendations for improvement.

(c) MEMBERS.—

(1) IN GENERAL.—Each Council shall consist of 11 members as follows:

(A) 5 members appointed by the President, to include representatives of business, labor, State government, and the public.

(B) 3 members appointed by the President pro tempore of the Senate, in consultation with the Chairman and ranking member of the Committee on Finance.

(C) 3 members appointed by the Speaker of the House, in consultation with the Chairman and ranking member of the Committee on Ways and Means.

(2) *QUALIFICATIONS.*—In appointing members under subparagraphs (B) and (C), the President pro tempore of the Senate and the Speaker of the House shall each appoint—

(A) 1 representative of the interests of business,

(B) 1 representative of the interests of labor, and

(C) 1 representative of the interests of State governments.

(3) *VACANCIES.*—A vacancy in any Council shall be filled in the manner in which the original appointment was made.

(4) *CHAIRMAN.*—The President shall appoint the Chairman.

(d) *STAFF AND OTHER ASSISTANCE.*—

(1) *IN GENERAL.*—Each council may engage any technical assistance (including actuarial services) required by the Council to carry out its functions under this section.

(2) *ASSISTANCE FROM SECRETARY OF LABOR.*—The Secretary of Labor shall provide each Council with any staff, office facilities, and other assistance, and any data prepared by the Department of Labor, required by the Council to carry out its functions under this section.

(e) *COMPENSATION.*—Each member of any Council—

(1) shall be entitled to receive compensation at the rate of pay for level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the actual performance of duties vested in the Council, and

(2) while engaged in the performance of such duties away from such member's home or regular place of business, shall be allowed travel expenses (including per diem in lieu of subsistence) as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(f) *REPORT.*—

(1) *IN GENERAL.*—Not later than February 1 of the second year following the year in which any Council is required to be established under subsection (a), the Council shall submit to the President and the Congress a report setting forth the findings and recommendations of the Council as a result of its evaluation of the unemployment compensation program under this section.

(2) *REPORT OF FIRST COUNCIL.*—The Council shall include in its February 1, 1994, report findings and recommendations with respect to determining eligibility for extended employment benefits on the basis of unemployment statistics for regions, States, or subdivisions of States.

Finder's Aid
P.L. 102-119 (105 Stat. 587) Approved October 7, 1991
Individuals with Disabilities Education Act Amendments of 1991

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>105 Stat.</u>	<u>H. Rep. 102-198</u>	<u>S. Rpt. 102-84</u>
Medicaid - Payment to States	1903(c)	26(i)(1)(A)	607	68-69	63-64
Medicaid - Payment to States	1903(c)	26(i)(1)(B)	607	68-69	63-64
Medicaid - Payment to States	1903(c)	26(i)(1)(C)	607	68-69	63-64
Medicaid - Provisions Respecting Inapplicability and Waiver of Certain Requirements	1915(c)(5) (C)(i)	26(i)(2)	607	69	64

Public Law 102-119
102d Congress

An Act

To amend the Individuals with Disabilities Education Act to strengthen such Act, and for other purposes.

Oct. 7, 1991
[S. 1106]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Individuals with Disabilities Education Act Amendments of 1991”.

SEC. 2. REFERENCES REGARDING INDIVIDUALS WITH DISABILITIES EDUCATION ACT.

Any reference made in this Act to an amendment or repeal of a provision shall be considered to be an amendment or repeal, respectively, of that provision of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), unless another public law is specified as being the subject of the amendment or repeal.

SEC. 3. DEFINITIONS FOR ACT IN GENERAL.

Section 602(a)(1) (20 U.S.C. 1401(a)(1)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(2) by inserting “(A)” after “(1)”; and

(3) by adding at the end thereof the following new subparagraph:

“(B) The term ‘children with disabilities’ for children aged 3 to 5, inclusive, may, at a State’s discretion, include children—

“(i) experiencing developmental delays, as defined by the State and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development; and

“(ii) who, by reason thereof, need special education and related services.”.

SEC. 4. SETTLEMENTS AND ALLOCATIONS.

(a) AMENDMENTS TO SUBSECTION (c).—Section 611(c)(2)(A)(i)(II) (20 U.S.C. 1411(c)(2)(A)(i)(II)) is amended by striking “\$350,000” and inserting “\$450,000”.

(b) AMENDMENTS TO SUBSECTION (f).—Section 611(f) (20 U.S.C. 1411(f)) is amended to read as follows:

“(f)(1) The Secretary shall make payments to the Secretary of the Interior to meet the need for assistance for the education of children with disabilities on reservations aged 5-21, inclusive, enrolled in elementary and secondary schools for Indian children operated or funded by the Secretary of the Interior. In the case of Indian students ages 3-5, inclusive, who are enrolled in programs affiliated with Bureau of Indian Affairs (hereafter in this subsection referred

Individuals with Disabilities Education Act Amendments of 1991.
Children and youth.
Inter-governmental relations.
20 USC 1400 note.

Indians.

part of Free Association with Palau takes effect pursuant to section 101(a) of Public Law 99-658”.

(b) PUBLIC LAW 101-476.—Section 901(b) of the Education of the Handicapped Act Amendments of 1990 (Public Law 101-476; 104 Stat. 1142) is amended in the matter preceding paragraph (1) by striking “Education for the Handicapped Act” and inserting “Individuals with Disabilities Education Act”.

SEC. 26. TECHNICAL AMENDMENTS TO OTHER ACTS.

(a) COMPREHENSIVE CHILD DEVELOPMENT ACT.—Section 670S(1) of the Comprehensive Child Development Act is amended by striking “Education of the Handicapped Act” and inserting “Individuals with Disabilities Education Act”. 42 USC 9886.

(b) DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT.—Sections 122(b)(5)(C) and 124(b)(3) of the Developmental Disabilities Assistance and Bill of Rights Act are each amended by striking “Education of the Handicapped Act” and inserting “Individuals with Disabilities Education Act”. 42 USC 6022, 6024.

(c) FOLLOW THROUGH ACT.—Section 663(b)(9) of the Follow Through Act is amended by striking “Education of the Handicapped Act” and inserting “Individuals with Disabilities Education Act”. 42 USC 9862.

(d) HEAD START TRANSITION PROJECT ACT.—Sections 136(a)(4)(C) and 136(a)(10) of the Head Start Transition Project Act are each amended by striking “Education of the Handicapped Act of 1975” and inserting “Individuals with Disabilities Education Act”. 42 USC 9855d.

(e) REHABILITATION ACT OF 1973.—Sections 101(a)(11), 304(d)(2)(D), 311(c)(3), 634(b)(2)(A), 634(b)(3)(D), and 705(a)(4)(C) of the Rehabilitation Act of 1973 are each amended by striking “Education of the Handicapped Act” and inserting “Individuals with Disabilities Education Act”. 29 USC 721, 774, 777a, 795m, 796d.

(f) TRIBALLY CONTROLLED SCHOOLS ACT OF 1988.—Sections 5204(a)(3)(C), 5205(a)(3)(B), 5205(b)(2)(B), and 5205(b)(3)(A)(ii) of the Tribally Controlled Schools Act of 1988 are each amended by striking “Education of the Handicapped Act” and inserting “Individuals with Disabilities Education Act”. 25 USC 2503, 2504.

(g) HEAD START ACT.—Section 640(d) of the Head Start Act is amended by striking “paragraph (1) of section 602 of the Education of the Handicapped Act” and inserting “section 602(a)(1) of the Individuals with Disabilities Education Act”. 42 USC 9835.

(h) HIGHER EDUCATION ACT OF 1965.—Section 465(a)(2) of the Higher Education Act of 1965 is amended by striking “section 602(1) of the Education of the Handicapped Act” and inserting “section 602(a)(1) of the Individuals with Disabilities Education Act”. 20 USC 1087ee.

(i) SOCIAL SECURITY ACT.—The Social Security Act is amended—
(1) in section 1903(c)—

(A) by striking “handicapped child” and inserting “child with a disability”;

(B) by striking “Education of the Handicapped Act” and inserting “Individuals with Disabilities Education Act”; and

(C) by striking “a handicapped infant or toddler” and inserting “an infant or toddler with a disability”; and

(2) in section 1915(c)(5)(C)(i), by striking “(as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16), (17)))” and inserting “(as defined in paragraphs (16) and (17) of section 602(a) of the Individuals with Disabilities Education Act)”. 42 USC 1396b, 1396n.

20 USC 241 note. SEC. 27. EFFECTIVE DATES AND APPLICABILITY.

(a) SECTIONS 8, 9, AND 10.—The amendments made by sections 8, 9, and 10 shall take effect on October 1, 1991, or on the date of enactment of this Act, whichever is later.

(b) SECTIONS 5, 12, 13, 14, 15, 17, AND 18.—The amendments made by sections 5, 12, 13, 14, 15, 17, and 18 shall take effect July 1, 1992, except that each State shall have the option to have any of the amendments apply earlier than such date.

(c) REMAINING PROVISIONS.—The remaining sections of this Act and the amendments made by such sections shall take effect on the date of the enactment of this Act.

Approved October 7, 1991.

LEGISLATIVE HISTORY—S. 1106 (H.R. 3053):

SENATE REPORTS: No. 102-84 (Comm. on Labor and Human Resources).
CONGRESSIONAL RECORD, Vol. 137 (1991):

June 24, considered and passed Senate.

Sept. 11, H.R. 3053 considered and passed House; S. 1106, amended, passed in lieu.

Sept. 16, Senate concurred in House amendment.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT
AMENDMENTS

JUNE 18 (legislative day, JUNE 11), 1991.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human
Resources, submitted the following

REPORT

[To accompany S. 1106]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1106) to reauthorize part H of the Individuals with Disabilities Education Act, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

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I. INTRODUCTION

On May 22, 1991, the Committee on Labor and Human Resources, by a unanimous voice vote, ordered favorably reported S. 1106, the Individuals with Disabilities Education Act Amendments of 1991.

The bill is sponsored by Senator Tom Harkin, chairman of the Subcommittee on Disability Policy (formerly the Subcommittee on the Handicapped), and cosponsored by Senators Durenberger, Kennedy, Hatch, Simon, Dole, Wellstone, Dodd, Bingaman, Adams, Jeffords, Cochran, and Kassebaum.

SEC. 5205. COMPOSITION OF GRANTS.

(a) IN GENERAL.—The grant provided under this part to an Indian tribe or tribal organization for any fiscal year shall consist of—

(1) * * *

* * * * *

(B) the [Education of the Handicapped Act] *Individuals with Disabilities Education Act*, and

* * * * *

(B) the [Education of the Handicapped Act] *Individuals with Disabilities Education Act*, and

* * * * *

(3)(A) * * *

* * * * *

(ii) the [Education of the Handicapped Act] *Individuals with Disabilities Education Act*, or

* * * * *

HIGHER EDUCATION ACT OF 1965

* * * * *

CANCELLATION OF LOANS FOR CERTAIN PUBLIC SERVICE

SEC. 465. (a) * * *

* * * * *

For the purpose of this paragraph, the term “children with disabilities” has the meaning set forth in [section 602(1) of the Education of the Handicapped Act] *section 602(a)(1) of the Individuals with Disabilities Education Act*.

* * * * *

SOCIAL SECURITY ACT

* * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * *

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a [handicapped child] *children with disabilities* because such services are included in the child's individualized education program established pursuant to part B of the [Education of the Handicapped Act] *Individuals with Disabilities Education Act* or furnished to a [handicapped infant or toddler] *infant or toddler with disabilities* because such services are included in the

child's individualized family service plan adopted pursuant to part H of such Act.

* * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN
REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) * * *

* * * * *

(5) * * *

* * * * *

(i) special education and related services [(as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), 17 (*as defined in section 602(a)(16) and (17) of the Individuals with Disabilities Education Act*) which otherwise are available to the individual through a local educational agency, and

* * * * *

INDIVIDUALS WITH DISABILITIES EDUCATION AMENDMENTS OF 1991

SEPTEMBER 11, 1991.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. FORD of Michigan, from the Committee on Education and Labor, submitted the following

REPORT

[To accompany H.R. 3053]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 3053) to amend the Individuals with Disabilities Education Act to strengthen such act, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in italic type in the reported bill.

I. SUMMARY

In reporting H.R. 3053, the Committee proposes to reauthorize Part H—the Infants and Toddlers with Disabilities program—of the Individuals with Disabilities Education Act for 3 years with several amendments to the Act. Amendments relate to: (1) transition from early intervention programs under part H to preschool

(ii) the [Education of the Handicapped Act] *Individuals with Disabilities Education Act*, or

* * * *

SECTION 640 OF THE HEAD START ACT

ALLOTMENT OF FUNDS; LIMITATIONS ON ASSISTANCE

SEC. 640. (a) * * *

* * * *

(d) The Secretary shall establish policies and procedures designed to assure that for fiscal year 1982 and thereafter no less than 10 percent of the total number of enrollment opportunities in Head Start programs in each State shall be available for children with disabilities (as defined in [paragraph (1) of section 602 of the Education of the Handicapped Act] *section 602(a)(1) of the Individuals with Disabilities Education Act*) and that services shall be provided to meet their special needs.

* * * *

SECTION 465 OF THE HIGHER EDUCATION ACT OF 1965

CANCELLATION OF LOANS FOR CERTAIN PUBLIC SERVICE

SEC. 465. (a) CANCELLATION OF PERCENTAGE OF DEBT BASED ON YEARS OF QUALIFYING SERVICE.—(1) * * *

(2) Loans shall be canceled under paragraph (1) for service—

(A) * * *

* * * *

(F) as a full-time law enforcement officer or corrections officer for service to local, State, or Federal law enforcement or corrections agencies.

For the purpose of this paragraph, the term “children with disabilities” has the meaning set forth in [section 602(1) of the Education of the Handicapped Act] *section 602(a)(1) of the Individuals with Disabilities Education Act*.

* * * *

SOCIAL SECURITY ACT

* * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * *

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to [a handicapped child] *a child with a disability* because such services are included in the child's individualized education program established pursuant to part B of the [Education of the Handicapped Act] *Individuals with Disabilities Education Act* or furnished to [a handicapped infant or toddler] *an infant or toddler with a disability* because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act.

* * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN
REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) * * *

* * * * *

(c)(1) * * *

* * * * *

(5) For purposes of paragraph (4)(B), the term "habilitation services", with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded—

(A) * * *

* * * * *

(C) does not include—

(i) special education and related services [(as defined in section 602 (16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401 (16), (17))] *(as defined in paragraphs (16) and (17) of section 602(a) of the Individuals with Disabilities Education Act)* which otherwise are available to the individual through a local educational agency; and

* * * * *

Finder's Aid

P.L. 102-234 (105 Stat. 1793) Approved December 12, 1991

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>105 Stat.</u>	<u>H. Rep. 102-310</u>	<u>H. Conf. Rep. 102-409</u>
Grants to States for Medical Assistance Programs	1902(h)	3(a)	1799	-	8-13, 18-19
Grants to States for Medical Assistance Programs	1902(t)	2(b)(1)(A)	1799	1-31	1-8, 16-18
Grants to States for Medical Assistance Programs	1902(t)	2(b)(1)(B)	1799	1-31	1-8, 16-18
Grants to States for Medical Assistance Programs	1903(a)(1)	3(b)(2)(B)	1803	-	8-13, 18-19
Grants to States for Medical Assistance Programs	1903(a)(1)	3(b)(2)(B)	1803	-	8-13, 18-19
Grants to States for Medical Assistance Programs	1903(d)(6)	4(a)	1804	-	13, 20
Grants to States for Medical Assistance Programs	1903(i)(10) Stricken	2(b)(2)	1799	-	1-8, 16-18
Grants to States for Medical Assistance Programs	1903(w) New	2(a)	1793	1-31	1-8, 16-18
Grants to States for Medical Assistance Programs	1923(a)(2) (B)	3(b)(2)(A) (i)	1802	-	8-13, 18-19
Grants to States for Medical Assistance Programs	1923(b)(4) New	3(c)	1803	-	8-13, 18-19

Grants to States for Medical Assistance Programs	1923(c)	3(b)(2)(A) (ii)	1803	-	8-13, 18-19
Grants to States for Medical Assistance Programs	1923(f) New	3(b)(1)	1799	-	8-13, 18-19

Public Law 102-234
102d Congress

An Act

To delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source.

Dec. 12, 1991

[H.R. 3595]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991".

SEC. 2. PROHIBITION ON USE OF VOLUNTARY CONTRIBUTIONS, AND LIMITATION ON THE USE OF PROVIDER-SPECIFIC TAXES TO OBTAIN FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.

(a) **IN GENERAL.**—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection.

"(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

"(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

"(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

"(II) donations described in paragraph (2)(C);

"(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

"(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

"(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

"(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as deter-

Medicaid
Voluntary
Contribution
and
Provider-
Specific Tax
Amendments of
1991.
42 USC 1305
note.

mined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

“(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

“(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

“(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

“(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

“(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

“(iii) In this subparagraph and subparagraph (E), the term ‘impermissible tax’ means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

“(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

“(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

Effective dates.

“(F) In this paragraph in the case of a State—

“(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

“(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

“(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in

1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

“(2)(A) In this subsection (except as provided in paragraph (6)), the term ‘provider-related donation’ means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

“(i) a health care provider (as defined in paragraph (7)(B)),

“(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

“(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

“(B) For purposes of paragraph (1)(A)(i)(I), the term ‘bona fide provider-related donation’ means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

“(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

“(3)(A) In this subsection (except as provided in paragraph (6)), the term ‘health care related tax’ means a tax (as defined in paragraph (7)(F)) that—

“(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

“(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

“(B) In this subsection, the term ‘broad-based health care related tax’ means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) and (E)—

“(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

“(ii) is imposed uniformly (in accordance with subparagraph (C)).

“(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

“(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

“(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

“(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

“(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

“(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

“(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

“(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

“(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

“(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

“(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

“(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

“(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph. Regulations.

“(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

“(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

“(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

“(C) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

“(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

“(B)(i) In subparagraph (A), the term ‘State base percentage’ means, with respect to a State, an amount (expressed as a percentage) equal to—

“(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

“(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

“(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

“(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

“(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

“(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

“(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

“(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

“(7) For purposes of this subsection:

“(A) Each of the following shall be considered a separate class of health care items and services:

“(i) Inpatient hospital services.

“(ii) Outpatient hospital services.

“(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

“(iv) Services of intermediate care facilities for the mentally retarded.

“(v) Physicians’ services.

“(vi) Home health care services.

“(vii) Outpatient prescription drugs.

“(viii) Services of health maintenance organizations (and other organizations with contracts under section 1903(m)).

“(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

“(B) The term ‘health care provider’ means an individual or person that receives payments for the provision of health care items or services.

“(C) An entity is considered to be ‘related’ to a health care provider if the entity—

“(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

“(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

“(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

“(iv) has a similar, close relationship (as defined in regulations) to the provider.

“(D) The term ‘State’ means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

“(E) The ‘State fiscal year’ means, with respect to a specified year, a State fiscal year ending in that specified year.

“(F) The term ‘tax’ includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty

imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

“(G) The term ‘unit of local government’ means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.”.

(b) CONFORMING AMENDMENTS.—(1) Section 1902(t) of such Act (42 U.S.C. 1396a(t)) is amended—

(A) by striking “Except as provided in section 1903(i), nothing” and inserting “Nothing”, and

(B) by striking “taxes (whether or not of general applicability)” and inserting “taxes of general applicability”.

(2) Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended by striking paragraph (10) inserted by section 4701(b)(2)(B) of the Omnibus Budget Reconciliation Act of 1990.

(c) EFFECTIVE DATE.—(1) The amendments made by this section shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date.

42 USC 1396a
note.

(2) Except as specifically provided in section 1903(w) of the Social Security Act and notwithstanding any other provision of such Act, the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure.

42 USC 1396b
note.

(3) The interim final rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56132), relating to the State share of financial participation under the medicaid program, is hereby nullified and is of no effect. No part of such rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 3. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) REPEAL OF PROHIBITION OF UPPER PAYMENT LIMIT FOR DISPROPORTIONATE SHARE HOSPITALS.—Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)) is amended by striking “to limit” the first place it appears and all that follows through “special needs or”.

(b) LIMITATION ON AGGREGATE PAYMENT ADJUSTMENTS.—

(1) IN GENERAL.—Section 1923 of such Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:
“(f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

“(1) IN GENERAL.—

“(A) APPLICATION OF STATE-SPECIFIC LIMITS.—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

“(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

“(I) the payment adjustments are made—

“(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991.

“(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

“(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

“(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

“(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as ‘DSH’) allotment for the year (as specified in paragraph (2)).

“(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

“(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

“(i) the national DSH payment limit for the fiscal year, and

“(ii) the State DSH allotment for each State for the year.

“(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

“(i) The hospital’s medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

“(ii) The hospital’s low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

“(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is

equal to at least 1 percent of the total number of such days for all hospitals in the State.

“(iv) The hospital meets such alternative requirements as the Secretary may establish by regulation, taking into account the special circumstances of children’s hospitals, hospitals located in rural areas, and sole community hospitals.

“(E) CONDITION FOR OPTION.—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a state exercising such option.

“(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

“(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

“(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

“(B) EXCEPTIONS.—

“(i) LIMIT TO 12 PERCENT OR BASE ALLOTMENT.—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State based allotment.

“(ii) EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

“(3) STATE SUPPLEMENTAL AMOUNTS.—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

“(A) DETERMINATION OF REDISTRIBUTION POOL.—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

“(i) the total of the State base allotments for high DSH States;

“(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

“(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal year; and

“(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

“(B) DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.—The supplemental amount for a State for a fiscal year is equal to the lesser of—

“(i) the product of the amount determined under subparagraph (A) and the ratio of—

“(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

“(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year, or

“(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

“(4) DEFINITIONS.—In this subsection:

“(A) HIGH DSH STATE.—The term ‘high DSH State’ means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

“(B) STATE.—The term ‘State’ means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

“(C) STATE BASE ALLOTMENT.—The term ‘State base allotment’ means, with respect to a State, the greater of—

“(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

“(ii) \$1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

“(D) STATE GROWTH AMOUNT.—The term ‘State growth amount’ means, with respect to a State for a fiscal year, the lesser of—

“(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year, or

“(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

“(E) STATE GROWTH FACTOR.—The term ‘State growth factor’ means, for a State for a fiscal year, the percentage by which the expenditures described in section 1903(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year.”

(2) CONFORMING AMENDMENTS.—(A) Such section 1923 is further amended—

(i) in subsection (a)(2)(B), by striking “subsection (c),” and inserting “subsections (c) and (f),”; and

(ii) in subsection (c), by striking “In order” and inserting “Subject to subsection (f), in order”.

(B) Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting “and section 1923(f)” after “of this section”.

(c) **LIMITS ON AUTHORITY TO RESTRICT DSH DESIGNATIONS.**— 42 USC 1396r-4.
Subsection (b) of such section is amended by adding at the end the following new paragraph:

“(4) The Secretary may not restrict a State’s authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4).”.

(d) **STUDY OF DSH PAYMENT ADJUSTMENTS.**—

42 USC 1396r-4
note.

(1) **IN GENERAL.**—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) **ITEMS INCLUDED IN STUDY.**—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) **REPORT.**—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

(e) **EFFECTIVE DATE.**—(1) The amendments made by this section shall take effect January 1, 1992. 42 USC 1396a
note.

(2) The proposed rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56141), relating to the standards for defining disproportionate share hospitals under the medicaid program, shall be withdrawn and can-

celed. No part of such proposed rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 4. REPORTING REQUIREMENT.

(a) **IN GENERAL.**—Section 1903(d) of the Social Security Act (42 U.S.C. 1396b(d)) is amended by adding at the end the following:

“(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

“(i) provider-related donations made to the State or units of local government during such fiscal year, and

“(ii) health care related taxes collected by the State or such units during such fiscal year.

“(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to fiscal years ending after the date of the enactment of this Act.

SEC. 5. INTERIM FINAL REGULATIONS.

(a) **IN GENERAL.**—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) **REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.**—The Secretary may not issue any interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that

42 USC 1396b
note.

42 USC 1396b
note.

are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) CONSULTATION WITH STATES.—The Secretary shall consult with the States before issuing any regulations under this Act.

Approved December 12, 1991.

LEGISLATIVE HISTORY—H.R. 3595:

HOUSE REPORTS: No. 102-310 (Comm. on Energy and Commerce) and 102-409 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 137 (1991):

Nov. 19, considered and passed House.

Nov. 26, considered and passed Senate, amended. House agreed to conference report.

Nov. 27, Senate agreed to conference report.

THE MEDICAID MORATORIUM AMENDMENT OF 1991

NOVEMBER 12, 1991.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce,
submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 3595]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 3595) to delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicare program and to maintain the treatment of intergovernmental transfers as such a source, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 2, beginning line 12, strike “and provide-specific taxes”.

Page 2, strike line 18 through page 3, line 2, and insert the following:

(2) In OBRA '90, Congress amended title XIX of the Social Security Act to prohibit the Secretary from denying or limiting Federal financial participation under the medicaid program to States for expenditures attributable to provider-specific taxes, except that the Secretary is permitted to deny or limit Federal financial participation if, in the case of certain facilities reimbursed on a cost basis, such expenditures are for costs attributable to taxes imposed solely with respect to such facilities.

Page 3, line 4, insert before “an interim” the following: “(and on October 31, 1991, withdrew, canceled, and republished)”.

Page 3, beginning line 9, strike “the limited” and all that follows through “such revenues” and insert the following: “the Secretary’s authority to impose such restrictions”.

Page 5, line 32, strike “September 30” and insert “October 1”.

Page 6, line 10, strike “Act.” and insert the following: “Act, including the treatment of such funds as a source of State share of financial participation under such title regardless of whether the public agency contributing the funds provides services under the State plan under such title.”.

Page 6, line 14, strike “TRANSACTION” and insert “TRANSITION”.

Page 7, strike lines 1 through 3 and insert the following:

(d) MORATORIUM ON REVISIONS OF ESTIMATED AMOUNTS.—Such section is further amended by adding at the end the following new subsection:

“(d) MORATORIUM ON REVISIONS OF ESTIMATED AMOUNTS.—

(1) IN GENERAL.—In estimating the amount to which a State will be entitled for a quarter under subsections (a) and (b) of section 1903 of the Social Security Act under section 1903(d)(1) of such Act, the Secretary may not withhold any amounts estimated to be expanded during the quarter (or reduce any amount so estimated pursuant to section 1903(d)(2)(A) of such Act) solely because the amounts are attributable to voluntary contributions, intergovernmental transfers, or provider-paid taxes.

(2) PERIOD OF APPLICABILITY.—Paragraph (1) shall apply—

(A) in the case of amounts attributable to intergovernmental transfers or provider-paid taxes, with respect to quarters beginning on or after January 1, 1992, and ending on or before September 30, 1992; and

(B) in the case of amounts attributable to voluntary contributions, with respect to quarters beginning on or after January 1, 1992, and ending on or before December 31, 1992.”.

(e) **MORATORIUM ON PENALTIES AND OTHER REGULATORY ACTIONS.**—Such section is further amended by adding at the end the following new subsection:

“(e) **MORATORIUM ON PENALTIES AND OTHER REGULATORY ACTIONS.**—

“(a) **IN GENERAL.**—The Secretary may not assess a penalty or take any compliance, disallowance, or other regulatory action against a State under or pursuant to title XIX of the Social Security Act on the basis of the State’s use of voluntary contributions, intergovernmental transfers, or taxes (Whether or not of general applicability) paid by, assessed against, or received from an individual or entity providing medical assistance under the State plan under such title to receive Federal matching funds under such title.

“(2) **PERIOD OF APPLICABILITY.**—Paragraph (1) shall apply with respect to actions taken by the Secretary—

“(A) on the basis of a State’s use of intergovernmental transfers or taxes during the period beginning on or after January 1, 1992, and ending on or before September 30, 1992; and

“(B) on the basis of a State’s use of voluntary contributions during the period beginning on or after January 1, 1992, and ending on or before December 31, 1992”.

PURPOSE AND SUMMARY

The purpose of H.R. 3595 is to prevent a major disruption of the Medicaid program on January 1, 1992—a disruption that would result in cuts in eligibility, benefits, and reimbursement in as many as 39 States. This crisis has been precipitated by the issuance of a regulation by the Secretary of Health and Human Services that is flatly inconsistent with the Medicaid statute and Congressional intent. While the Committee has every expectation that the courts will strike this regulation down, it is uncertain whether they will do so before January 1. The Committee therefore reports this legislation to protect the States and Medicaid beneficiaries from the imminent and drastic impact of the Secretary’s illegal regulation.

The bill would prohibit the Secretary from implementing any regulation that would change current policy with respect to the use by the States of revenues from voluntary contributions, provider-specific taxes, and intergovernmental transfers to finance their share of the Medicaid program. With respect to voluntary contribu-

tions and provider-specific taxes, this moratorium on action by the Secretary would extend from January 1, 1992, through September 30, 1992, with an additional transition period to enable States to phase out the use of voluntary contributions by December 31, 1992. With respect to intergovernmental transfers, this moratorium would be permanent. The bill directs the Secretary to submit any legislation he feels is necessary by no later than February 3, 1992, to allow the Congress sufficient time to consider and enact any changes in current statutory policy that may be warranted.

BACKGROUND AND NEED FOR THE LEGISLATION

CURRENT LAW

Medicaid is a Federal-State, means-tested entitlement program that purchases basic medical care and long-term care services on behalf of 28 million poor people. The Federal government shares in the cost of Medicaid services through a variable matching formula. The rate at which the Federal government matches State Medicaid expenditures for covered services currently ranges from 50 to 80 percent; States with lower per capita incomes receive a higher matching rate. The Federal share of State expenditures for administration of the Medicaid program is, with the exception of certain activities, 50 percent in all States. In the aggregate, according to the Congressional Budget Office, the Federal share of total Medicaid spending was 57 percent in Fiscal Year 1991.

The issue addressed by this bill is a narrow one: what funds may States use to pay their share of Medicaid program expenditures and received Federal matching funds (known as Federal financial participation, or FFP)? The question is fundamental to the operation of the program. In order to receive Federal matching payments, States must first spend money to purchase covered services on behalf of eligible individuals from qualified providers. Fiscal prudence makes States highly reluctant to spend money purchasing services unless they are reasonably certain that their expenditures will qualify for Federal matching payments.

Current law sets forth the rules under which States can determine what funds they may use to pay their share of Medicaid expenditures. Under section 1902(a)(2) of the Social Security Act, a State, itself, must provide at least 40 percent of the non-Federal share of program spending; up to 60 percent of the non-Federal share can come from localities, so long as the State assures that State and Federal Medicaid funds are distributed on an "equalization or other basis" so that "lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available." As of September, 1991, fourteen States required localities to fund at least some portion of the non-Federal share of Medicaid expenditures.

There are three categories of funds for which specific rules have evolved: voluntary contributions, provider-specific taxes, and intergovernmental transfers.

Voluntary contributions

Current law with respect to the use of voluntary contributions or donated funds is set forth in HCFA regulations at 42 C.F.R.

433.45(b). This regulation was promulgated by the Reagan Administration in 1985 to allow private donations to be used as a State's share of financial participation in the entire Medicaid program, not just training expenditures, as under previous policy. In explaining this change, HCFA stated: "The revision permits States more flexibility in administering their programs and reduces the recordkeeping necessary to relate donated funds exclusively to training expenditures," 50 Fed. Reg. at 46657 (Nov. 12, 1985).

The 1985 HCFA rule allows funds donated from private sources to be considered as the State's share in claiming Federal Medicaid matching funds if the following two conditions are met: (1) the funds are "transferred to the State of local Medicaid agency and are under its administrative control," and (2) the funds "do not revert to the donor's facility or use unless the donor is a non-profit organization, and the Medicaid agency, of its own volition, decided to use the donor's facility."

The Secretary is currently prohibited from issuing any final regulation changing the treatment of voluntary contributions prior to December 31, 1991. This moratorium was first enacted as section 8431 of the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), then extended by section 6411(b) of the Omnibus Reconciliation Act of 1989 (P.L. 101-239), and extended again by section 4701(a) of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508).

According to HCFA, as of September 15, 1991, the following 21 States use revenues from provider donations to help fund their Medicaid programs: Alabama, California, Florida, Georgia, Idaho, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, North Carolina, Oregon, Pennsylvania, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming.

Provider-specific taxes

Current law with respect to the treatment of provider-specific taxes was enacted as section 4701(b) of OBRA '90. The general rule, codified at section 1902(t) of the Social Security Act, is that the Secretary is without authority to deny or limit Federal matching payments to a State for Medicaid expenditures "attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items of services [i.e., Medicaid-covered services]." In other words, the law provides that, as a rule, States may use revenues from provider-specific taxes to finance their share of Medicaid program spending.

The law provides one narrow exception to this general rule. It is codified at section 1903(i)(10) of the Social Security Act. In cases where a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR) is reimbursed on a cost basis, Federal matching funds are not available with respect to "the costs attributable to taxes imposed by the State solely with respect to hospitals or facilities." This exception, therefore, could apply only in those States which reimburse such providers on a cost basis. The Committee notes that the costs that would not qualify for Federal matching payments under this exception can readily be determined from the uniform cost reports required to be filed by each hospital, nursing facility, or ICF/MR under section 1902(a)(13)(A) of the Act.

The general rule and this exception are effective January 1, 1991, but the Secretary is prohibited from issuing regulations implementing this provision until after December 31, 1991.

According to HCFA, as of September 15, 1991, the following 27 States use revenues from provider-specific to help fund their Medicaid programs: Alabama, Arkansas, California, Colorado, Florida, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, South Carolina, Tennessee, Texas, Vermont, and Washington.

Current law with respect to provider-specific taxes represents a compromise negotiated during the consideration of the conference agreement on OBRA '90. That compromise, and the process by which it was reached in a House-Senate subconference on Friday, October 26, 1990, are described in detail in a letter dated August 15, 1991, to the Administrator of HCFA. Dr. Gail Wilensky, from the Chairman of the Subcommittee on Health and the Environment. That letter states, in relevant part:

As you remember, the negotiations began at 12:30 a.m. and concluded at 7:30 a.m. I represented the House conferees. The Senate conferees were Senators Rockefeller, Pryor, and Chafee. At the request of the Senate, and with the concurrence of the House conferees, you and members of your staff were allowed to remain in the room to provide technical assistance to the Senate minority.

Coming into the conference, the House position was (1) to grant permanent authority to the States to use voluntary donations from hospitals to finance Medicaid spending under certain circumstances, and (2) to prohibit the Secretary from denying Federal matching payments to States for Medicaid spending financed by taxes on providers. The Senate position was to extend the moratorium barring the Secretary from issuing final regulations to disallow Medicaid spending based on voluntary contributions or provider taxes from December 31, 1990, until September 1, 1991.

When the negotiations reached this particular issue, the House offered to accept the Senate position on voluntary contributions, but to extend the moratorium until September 30, 1995, in exchange for a Senate agreement to accept the House provision on provider taxes. The Senate insisted on its position on voluntary contributions, citing an estimate by Mr. Scully from the Office of Management and Budget that extending the moratorium beyond 1991 would cost the Federal government \$1.7 billion over the next five years. The Senate also offered to accept the House language on provider taxes with an exception to exclude provider taxes from the cost base of providers for purposes of establishing Medicaid payment rates.

The House offered to accept an extension of the moratorium on repealing the voluntary contributions regulations until December 31, 1991, if the Senate would accept the House language on provider-specific taxes. The Senate in-

sisted on its exception to the House language. In response to a request from House staff for clarification, you stated that the purpose of this exception was to avoid a situation in which Federal Medicaid funds were being used to pay hospitals, nursing homes, and other providers that are reimbursed on a cost basis for the costs attributable to the provider-specific tax. What I understood this to mean was, for example, if a State imposed a licensure fee or assessment on hospitals, and if the State paid its hospitals on a cost basis, the Federal Medicaid matching funds would not be allowed for that portion of the hospital's reimbursement attributable to the fees or assessments.

On the basis of your clarification, the House agreed to the compromise. The statutory language, which was drafted later that same day with the help of your staff, reflects this understanding. First, there is the broad general rule, taken verbatim from the House bill, that the Secretary has no authority "to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services." Then there is the exception, based on your representations, which denies Federal Medicaid matching funds for payments to hospitals and other institutional providers "for the costs attributable to taxes imposed by the State solely with respect to hospitals or facilities." The statement of managers, which was written that same day, confirms that the conference agreement "includes the House bill with an amendment to exclude taxes from a provider's cost base for purposes of Medicaid reimbursement.

While the States were given until December 31, 1991, to phase out voluntary contributions, the conferees made the provider-specific tax provisions effective January 1, 1991. Since the policy with respect to provider-specific taxes had been codified, and the exception so narrowly drawn, there was no reason to prohibit the Secretary from issuing regulations implementing the new statutory language after its January 1, 1991, effective date. However, due to a drafting error in OBRA '90, the moratorium on the issuance of regulations was inadvertently applied to regulations changing the treatment of provider-specific taxes as well.

Intergovernmental transfers

Under current law, States may use public funds (other than Federal funds) as a source of their share of Medicaid program expenditures. HCFA's current regulation, 42 C.F.R. section 433.45(a), states that "public funds may be considered as the State's share in claiming FFP [Federal financial participation]" if the following conditions are met. First, the funds may not be Federal funds, or, if they are Federal funds, they must be "authorized by Federal law to be used to match other Federal funds." Second, the funds must either be (1) "appropriated directly to the State or local Medicaid agency," (2) "transferred from other public agencies (including Indian tribes)

to the State of local agency and under its administrative control," or (3) "certified by the contributing public agency as representing expenditures eligible for FFP."

In his letter of August 15, 1991, to Dr. Wilensky, the Chairman of the Subcommittee on Health and the Environment made the following observation relating to the treatment of intergovernmental transfers. This observation reflects the Committee's understanding of the effect of OBRA '90 on intergovernmental transfers: "The notion of barring these long-standing, widely-used transfer arrangements was never raised by you any of your staff in the OBRA '90 Medicaid subconference or in the drafting sessions thereafter. I can assure you that none of the House conferees had any understanding that our compromise on the issue of voluntary contributions or provider taxes would be construed by HCFA as authorization to terminate these transfers of public, non-Federal funds. Had the issued been raised, we would have vigorously opposed any change in current policy or practice."

THE SEPTEMBER 12, 1991 REGULATION

On September 12, 1991, the Secretary published an interim final rule "with comment" that radically alters the treatment of revenues from voluntary contributions, provider-specific taxes, and intergovernmental transfers as the State share of Medicaid spending (56 Fed. Reg. 46380). The rule applies to State Medicaid expenditures incurred on or after January 1, 1992.

With respect to voluntary contributions, the regulation requires that, in calculating Federal matching funds, there be excluded from State expenditures the amount of any revenue to a State resulting from either donations or other voluntary payments made to the State, county, or any other government instrumentality, by or on behalf of health care providers.

With respect to provider-specific taxes, the regulation provides that Federal matching funds are not available for that portion of States' repayment applicable to the Medicaid program to facilities for costs attributable to a provider-specific tax (i.e., a tax paid by a provider and imposed solely with respect to hospitals, nursing facilities, or intermediate care facilities for the mentally retarded). Under the rule, a provider is considered to be reimbursed for the costs attributable to the tax not just when a cost-reimbursed provider includes the cost of the tax on its cost report, but whenever there is "linkage" between payment to the provider and the tax program (i.e., where the payment is "significantly is correlated" to the tax, the provider is "held harmless," or the increase in provider payments "integrally is related" to the tax program).

With respect to intergovernmental transfers, the regulation repeals the current regulatory authority (42 C.F.R. 433.45(a)) for use of public funds as the State share of Medicaid expenditures. Whenever public funds are transferred to the State Medicaid agency from a State or local agency that is (or has an ownership interest in) a health care provider, the funds would be treated as either donations or provider-specific taxes and therefore be disallowed for purposes of receiving Federal Medicaid matching funds.

SUBCOMMITTEE OVERSIGHT HEARINGS

Neither the preamble to the September 12 regulation nor the text itself identified (1) which States were using revenues from provider-specific taxes or intergovernmental transfers as their share of Medicaid expenditures, (2) which of those arrangements would or would not be subject to disallowance of Federal matching funds as of January 1, 1992, and (3) what changes these States should make in their programs to bring themselves into compliance with HCFA's interpretation of the law. The absence of this basic information, combined with the broad, ambiguous scope of the regulation itself, prompted the Subcommittee on Health and the Environment to hold two oversight hearings.

The first of these was scheduled for September 30, 1991—more than two weeks after the publication of the rule, and just three months before its effective date. The Administrator of HCFA, Dr. Wilensky, was invited to testify and explain the impact of the regulation on the States. She declined to appear, saying she was not prepared to discuss the impact of the regulation at that time, and promised instead to appear before the Subcommittee on October 16. The Subcommittee proceeded with its hearing on September 30, taking testimony from Governors and State officials.

In the preamble to the September 12 regulation, the Department wrote, "It is difficult to anticipate precisely what action States will take as a result of this interim final rule." The witnesses at the Subcommittee's September 30 hearing had no similar difficulty. The Governor of Kentucky, the Honorable Wallace G. Wilkinson, testified that the regulation would require his State, which funds about 30 percent of its share of Medicaid from Provider-specific taxes, to make "dangerous" reductions in eligibility, benefits, and reimbursement, including the termination of coverage to 16,000 low-income pregnant women, and infants. The Governor of Oklahoma, the Honorable David Walters, testified that in his State, which relies on intergovernmental transfers to fund 16 percent of its share of the program, the regulation could result in the elimination of immunizations to 10,000 low-income children, the loss of access to prenatal care by 1,000 low-income pregnant women, and the eviction of up to 9,000 elderly individuals from nursing homes.

On October 16, 1991, the Subcommittee on Health and the Environment held a second oversight hearing on this subject at which Dr. Wilensky, the HCFA Administrator, testified on behalf of the Administration. As part of her testimony, she candidly acknowledged that "our rulemaking is disruptive and controversial." But she was unable to explain the scope of the disruption with any precision. The Subcommittee questioned her with regard to each of the following States, all of which currently rely on provider-specific taxes: Alabama, Arkansas, Florida, Illinois, Indiana, Kentucky, Maine, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New York, Ohio, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. In each case, she was asked, under the Administration's interpretation of its own regulation, (1) whether the State would be able to continue using revenues from its provider-specific taxes to draw down Federal matching funds after January 1, 1992, (2) if not, how much HCFA would disallow, and (3) how

the State could restructure its provider tax in order to qualify the revenues for Federal matching funds after January 1. In each case, Dr. Wilensky was unable to give a definitive answer. She did, however, promise to issue a "clarification" that "will correct" several deficiencies in the September 12 version of the regulation.

THE OCTOBER 31, 1991 "CLARIFICATION"

On October 31, 1991, the Secretary withdrew and canceled the interim final rule of September 12, 1991, and published an interim final rule "with comment" (56 Fed. Reg. 56132). The October 31 regulation, like the September 12 version, is effective January 1, 1992—just two months after its publication.

With respect to voluntary contributions, the October 31 regulation provides that the amount of any donations made to a State, a county, or any other governmental instrumentality by or on behalf of health care providers will be subtracted from State expenditures for purposes of calculating the amount of Federal Medicaid matching funds.

With respect to provider-specific taxes, the October 31 regulation states that, if any level of State government imposes a provider-specific tax, and if any level of State government reimburses the providers subject to the tax for costs attributable to the tax imposed (i.e., whenever there is "linkage" between the payment to the provider and the tax program), State expenditures will be disallowed for purposes of calculating Federal matching payments. The specific amount disallowed will be the lesser of (1) the total amount of the provider-specific tax paid by the provider; or (2) the amount of Medicaid payment received by the provider attributable to such taxes. Provider-specific taxes are defined as taxes imposed solely with respect to hospitals, nursing facilities, or ICFs/MR.

With respect to intergovernmental transfers, the October 31 regulation provides that public funds may be included in the State's share of Medicaid spending for purposes of calculating Federal matching payments if the same conditions are met as under current law. That is, the funds are not Federal funds (or if Federal, are authorized for this purpose), and they are either (1) appropriated directly to the State or local Medicaid agency, (2) transferred from other public agencies to the State or local agency and under its administrative control, or (3) certified by the contributing public agency as representing expenditures eligible for Federal matching. In addition, the October 31 rule adds a new requirement: the public funds may be included in the State's share only if they are not "generated through a provider-specific tax or a donation."

As noted above, the October 31 regulation is effective January 1, 1992. However, the regulation contains a provision allowing the Secretary to grant States what amounts to a 6-month reprieve from the disallowance of Federal Medicaid matching funds on a case-by-case basis. In order to qualify for this reprieve, a State must have had in effect, as of September 12, provider-specific tax or donation arrangements, and it must agree in writing to eliminate the use of provider-specific tax or donations for the State share of Medicaid expenditures by July 1, 1992. If HCFA grants the State's application for a reprieve, and if the State takes the necessary legislative

or administrative steps to eliminate the use of provider-specific taxes or donations by July 1, then the State will not be subject to disallowance of Federal matching funds during the first 6 months of 1992. However, if the State fails to eliminate donations and provider-specific taxes by that date, it will be subject to a disallowance of Federal matching funds retroactive to January 1, 1992.

As with the September 12 rule, neither the preamble nor the text of the October 31 "clarification" sets forth any information regarding the impact of this regulation on those States that currently rely on revenues from provider taxes or intergovernmental transfers to help pay their share of the Medicaid program. This silence is particularly troubling in light of the strenuous efforts of the Subcommittee on Health and the Environment to obtain this basic information from HCFA through not one but two oversight hearings.

Based on information describing state provider tax arrangements provided to the Committee by the American Public Welfare Association and the Committee's analysis of the regulation, it appears that every State that currently uses revenues from provider-specific taxes would be subject to a disallowance of Federal funds under the October 31 rule, irrespective of whether they pay their providers on a cost basis. The only question is the amount of the disallowance.

In short, it appears that the Secretary has attempted by regulation to convert the statutory provision enacted in OBRA '90 from a general authorization for States to use the revenues from provider-specific taxes into a broad prohibition against the use of provider-tax revenues. The only type of hospital-specific tax that would not be subject to any disallowance under this regulation is a tax under which the hospitals subject to the tax received absolutely no Medicaid payments, and those receiving Medicaid reimbursements paid absolutely no tax. This result is compelled by the logic of the regulation's "lesser of" rule: only if either (1) the amount of the tax paid or (2) the amount of the payment received is zero in the case of every hospital in the State will the amount of the State expenditures disallowed be zero.

There is nothing in the statutory language enacted in OBRA '90 or elsewhere in the Title XIX of the Social Security Act which contemplates, much less authorizes, such an illogical and patently impractical result. Nor is this result in any way related to what is stated in the statute: a general rule authorizing provider-specific taxes, and a narrow exception for institutional providers paid on a cost basis. Had the Congress intended to limit States to the use of revenues from the singular type of tax arrangement permitted under this regulation, it would have likely have said so by leaving section 1902(t) of the Social Security Act intact and by drafting the exception at section 1903(i)(10) to read as follows:

(i) [Federal Medicaid matching payments shall not be made]—

(10) with respect to any calendar quarter beginning on or after July 1, 1992, for (A) any amounts expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded that are directly or indirectly attributa-

ble to any taxes imposed solely upon such hospital or facility by the State or local government, or (B) the total amount of such taxes are by such hospital, nursing facility, or intermediate care facility for the mentally retarded, whichever is lesser.

While the October 31 regulation lacks any statutory basis, unless the Secretary is prohibited from implementing it, the consequences for program beneficiaries will be drastic. Perhaps nowhere will the effects of this regulation be more keenly felt than in Alabama, 20 percent of those citizens live below the Federal poverty level, and 40 percent of whose share of Medicaid spending derives from provider-specific tax revenues. According to a complaint for declaratory and injunctive relief filed by the State's Attorney General on November 5, the October 31 rule, by forcing the State to reduce its annual Medicaid expenditures by \$800 million, "will virtually destroy the Medicaid program in Alabama. *Alabama v. Sullivan*, No. 91-V-1343-N (M.D. Ala., filed Nov. 5, 1991). The Attorney General alleges that, if the October 31 rule is not enjoined, Alabama will (1) "eliminate the entire Medicaid pharmaceutical coverage program;" (2) lower the income threshold for nursing home residents from \$1,221 to \$300 per month, resulting in the termination of coverage for 9,929 current eligibles; (3) reduce from 14 to 10 the number of covered inpatient hospital days per year; (4) reduce reimbursement levels to hospitals and nursing facilities, forcing "several" rural hospitals to close due to reimbursement shortfalls, and (5) no longer be able to sustain the advances it has made in providing access to care for pregnant women and infants, resulting in "a rapid rise in [infant] mortality."

These outcomes are precisely what this Committee—and the Congress—attempted to avoid in OBRA '90 by authorizing States to use revenues from provider-specific taxes to fund their share of Medicaid expenditures. It is particularly ironic that Alabama should run afoul of the October 31 regulation, because it is one of the States that had been relying on provider donations since 1987, and, after the passage of OBRA '90, ended its provider donation program and enacted provider-specific taxes.

But perhaps the most extraordinary aspect of this regulation is the provision for a 6-month reprieve from the disallowance of Federal Medicaid matching funds for States which agree to end their reliance on voluntary contributions or provider-specific taxes by July 1, 1992. The Committee can certainly understand the political logic of this reprieve. The January 1, 1992 effective date falls right in the middle of most State fiscal years, threatening severe disruption to those State budgets that had assumed the availability of the Federal matching funds. To avoid forcing States to call special sessions of their legislatures to deal with this budgetary crisis, and to defuse political opposition to the October 31 regulation itself, the Secretary has decided to offer States an additional 6 months of Federal Medicaid funds—so long as they agree to desist from funding their share of the program through donations or provider-specific taxes. In effect, this extraordinary provision of the regulation gives a 6-month reprieve to States which accede to the Administration's illegal interpretation of the statute.

What this regulatory reprieve has in political logic, it lacks in statutory authority. There is nothing in either the statutory language of OBRA '90 or the rest of the Social Security Act that suggests, must less authorizes, the Secretary to waive this effective date on a case-by-case basis. The Committee sees no need for any such authority, since, under a proper interpretation of the statute, all States were allowed (with one narrow exception) to use revenues from provider-specific taxes as their share of Medicaid expenditures as of January 1, 1991, and all States were given until January 1, 1992, to end their reliance on voluntary contributions. The Committee is extremely concerned that the 6-month reprieve provisions in the October 31 regulation pose a dangerous precedent for the integrity of the Medicaid program by establishing a process under which the Administration has authorized itself to condition receipt of Federal matching funds to States on agreements to forsake options specifically allowed by statute.

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

FINDINGS; PURPOSES (SECTION 2)

The Committee bill sets forth the following findings:

(1) In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress extended until December 31, 1991, a moratorium prohibiting the Secretary from changing the treatment of voluntary contributions as a source of a State's share of Medicaid spending. Congress expressed no intention to change the treatment of intergovernmental transfers as such as source.

(2) In OBRA '90, Congress amended the Medicaid statute to prohibit the Secretary from denying or limiting Federal matching funds to States for expenditures attributable to provider-specific taxes, with one exception. The Secretary is permitted to deny or limit Federal funds if, in the case of certain facilities reimbursed on a cost basis, the expenditures are attributable to taxes imposed solely with respect to such facilities.

(3) On September 12, the Secretary published, and then on October 31, 1991, cancelled, withdrew, and republished an interim final regulation that purports to implement section 4701 of OBRA '90. This regulation would impose restrictions on the use of State revenues attributable to provider-specific taxes that go far beyond the Secretary's authority to impose such restrictions. It may have the effect of denying Federal matching payments for expenditures that are attributable to intergovernmental transfers, an outcome that was never intended by Congress when it enacted OBRA '90. Finally, it does not provide adequate guidance to States as to what specific types of provider-specific taxes may be used as a source of the State share.

(4) The Secretary intends to republish this regulation as a final regulation on or about January 1, 1992, effective as of the date of republication. States enacted budgets for State fiscal years which began before the date of publication of the interim final regulation, in anticipation of an appropriate interpretation of the provisions of OBRA '90.

(5) Because of the unanticipated fiscal impact of such a regulation in the middle of State fiscal years, many States will be required to enact emergency legislation or to take other emergency measures, including reductions in eligibility, benefits, or reimbursement under their Medicaid plans, in order to continue to assure that previously enacted State budgets remain balanced.

(6) The Federal government should not take unilateral administrative actions that have the practical effect of prohibiting States from using State and local taxes to pay for covered services on behalf of eligible individuals under the Medicaid program.

The Committee bill has the following purposes:

(1) to delay the issuance of regulations changing the treatment of voluntary contributions and provider-specific taxes in order (A) to avoid disruptions in State budgets during the middle of State fiscal years and (B) to provide the Secretary with additional time to issue regulations that conform to OBRA '90;

(2) to maintain current regulations at 42 C.F.R. 433.45 that permit Federal financial participation for intergovernmental transfers; and

(3) to provide Congress with information in order to enact legislation to maintain Federal financial participation for State revenues generated by legitimate voluntary contributions.

USE OF VOLUNTARY CONTRIBUTIONS, PROVIDER-SPECIFIC TAXES, AND INTERGOVERNMENTAL TRANSFERS BY STATES TO RECEIVE FEDERAL MATCHING FUNDS UNDER MEDICAID (SECTION 3)

(a) Delay in changes in regulations concerning voluntary contributions and provider-specific taxes

The Committee bill would prohibit the Secretary from issuing any regulation (final, interim final, proposed, or otherwise) prior to September 30, 1992, changing the treatment of voluntary contributions or provider-paid taxes utilized by States to receive Federal matching funds under title XIX of the Social Security Act.

The Committee emphasizes that the moratorium would apply to voluntary contributions used to pay for expenditures for Medicaid administrative activities, as well as to expenditures for covered services. These administrative activities include general eligibility determination activities, "outstationed" eligibility determination activities for low-income pregnant women and children under section 1902(a)(55) of the Social Security Act, and program management activities such as the recruitment and training of new clinicians to deliver early and periodic screening, diagnostic, and treatment (EPSDT) services. The Committee notes that States commonly rely on funds donated by public and private nonprofit providers to support enrollment and eligibility determination activities on an "outstationed" basis at hospitals, maternal and child health clinics, Federally qualified health centers, and other sites at which low-income people obtain health care. The Committee bill moratorium would protect contributions for these purposes from the disallowance of Medicaid matching funds.

(b) Maintaining treatment of intergovernmental transfers

The Committee bill would prohibit the Secretary from issuing any regulation that changes the treatment (specified in 42 C.F.R. 433.45(a)) of public funds as a source of State share of financial participation under title XIX of the Social Security Act. This prohibition is permanent. It would apply to all public funds used as a source of the State share, regardless of whether the public agency contributing the funds is a health care provider delivering services under the State's Medicaid program.

The Committee stresses that, under this bill, intergovernmental transfers that are not subject to disallowance of Federal matching funds include any public funds received by the State Medicaid agency from public entities or local units of government that function as health care providers, including State or local health agencies, counties that operate hospitals or public health departments, public hospital districts, school districts that operate their own school health programs, State institutions for individuals with mental retardation, State residential treatment programs for children with severe education-related disabilities. So long as the transfer of public funds (for either covered services or administrative activities) is made by or through a general or special purpose unit of State or local government, the transfer is protected under the current regulation and under the moratorium on changes in that regulation, regardless of whether the unit of government is also a health care provider.

For example, a hospital district may transfer or certify to the State Medicaid agency a portion of its revenues, which may be collected by the district's facilities as payment for services rendered, or through its special taxing authority. The district may transfer "hard" dollars, or may simply certify to the State that funds have been expended. The expenditures may be for covered services provided to Medicaid eligibles, or for administrative expenditures relating to eligibility determinations for hospital patients. The transfer or certification may be made by the hospitals themselves, or by the district governing body. The agency making or certifying the transfer may itself be certified by the State agency as a qualified Medicaid provider. The transfer or certification may be mandated by State law, or may be undertaken by the district on a voluntary basis. In any of these circumstances, the transfer or certification of public funds is protected under both the current regulation and the Committee bill moratorium from the denial or limitation of Federal matching funds.

In its discussion of intergovernmental transfers in the preamble to the October 31 regulation, HCFA states, "we are concerned that this may be an area of potential abuse and States should be on notice that this may be the subject of further review to assure that States maintain their appropriate shares of Medicaid financing" (56 Fed. Reg. at 56136). The Committee wishes to remind the HCFA of the lack of statutory authority for such actions. Also, the moratorium in the Committee bill is permanent and applies to all public funds used as a source of the State share of Medicaid expenditures, including those from public entities or units of government that are also health care providers that participate in Medicaid. If the

Secretary believes that any change in current statutory policy is warranted, he should present his legislative recommendations to this Committee and to the Congress. Under current law, he is without authority to make any changes in current policy or practice through regulation or administrative procedures. The committee bill makes this explicit.

(c) Transition for voluntary contributions

The Committee bill provides that any regulation that changes the treatment of voluntary contributions utilized by States to receive Federal Medicaid matching funds shall not apply to voluntary contributions made before January 1, 1993. The Committee assumes that, when the moratorium imposed by the bill expires, the Secretary is likely to issue regulations that ultimately eliminate, or severely restrict, the use of voluntary contributions as a source of State share. In order to avoid program disruption, the bill would give those States that during during FY 1991 relied on revenues from provider donations and other voluntary contributions the benefit of an additional calendar quarter to transition to other funding sources, such as provider-specific taxes. The amount of Federal matching payments during FY 1993 that results from the State's use of voluntary contributions during the calendar quarter ending December 31, 1993, may not exceed the amount of Federal matching funds received by that State during the four quarters of FY 1991 that resulted from the State's use of voluntary contributions.

(d) Moratorium on revision of estimated amounts

The purpose of the Committee bill is to protect the flexibility that States have under current law to use revenues from voluntary contributions, provider-specific taxes, and intergovernmental transfers as the State share of Medicaid spending. The moratorium on implementation of any regulation changing the current treatment of these financing methods should accomplish that purpose. However, to ensure that the Secretary does not do indirectly what he is prohibited from doing by regulation, the Committee bill would also prohibit the Secretary from using administrative mechanisms, such as the estimation and disallowance processes, to effectively prevent the States from using revenues from voluntary contributions, provider-specific taxes, and intergovernmental transfers to help pay for their Medicaid programs.

The Committee regrets the apparent necessity of legislating prohibitions on Administration actions which, under any reasonable reading of the current statute or section 3(a) of the bill, would be unnecessary. It is only the Secretary's disregard of the statute that gives rise to the Committee's concern. Moreover, the inclusion in the Committee bill of the moratoria on revisions of estimated amounts and on penalties should not be construed as an acknowledgment that the Secretary has authority not granted by the statute, but rather as a concern, based on Secretarial action to date, that the Department may divine such authority to the detriment of the States and program beneficiaries.

The estimation process is one administrative route that HCFA might choose to use to circumvent the regulatory moratorium if it intends to continue disregarding the will of the Congress. Under

current law, each State submits, on a quarterly basis, an estimate of the expenditures it expects to make on the Medicaid program. Based upon the State's report, HCFA then makes an estimate of the Federal financial participation to which the State is entitled for the quarter involved and issues a grant award to cover its estimate of the level of State expenditures.

The Committee bill would prohibit the Secretary from reducing the quarterly expenditure estimates submitted by the States or from withholding amounts paid in quarterly grants to the States solely because the estimated expenditures would be paid for with revenues derived from voluntary contributions, provider-specific taxes, or intergovernmental transfers. In the case of amounts attributable to contributions or taxes, this prohibition would apply with respect to the calendar quarters beginning January 1, 1992, and ending September 30, 1992; in the case of amounts attributable to voluntary contributions, with respect to calendar quarters beginning January 1, 1992, and ending December 31, 1992.

This is not an academic issue. The Committee is informed that HCFA has already notified at least two States that their annual grant awards for FY 92 will be reduced by the amounts HCFA believes are attributable to revenues from their provider-specific tax arrangements until HCFA can satisfy itself that the arrangements are consistent with its new, unimplemented regulation. The Committee is troubled by these reports, and stresses that such manipulation of the estimation process is not authorized by current law and is impermissible under the moratorium established by the bill.

(e) Moratorium on penalties and other regulatory actions

The disallowance process is another administrative route that the Secretary might choose to use to circumvent the regulatory moratorium. Under current law, after each quarter, each State files a report of its actual Medicaid expenditures. These reports are reviewed by HCFA for compliance with Federal requirements under the Medicaid statute and regulations. The amounts allowed by HCFA as appropriate expenditures become the basis for the Federal financial participation to which the State is formally entitled. When HCFA believes that a reported expenditure does not qualify for Federal financial participation, HCFA disallows that portion of the State's reported expenditure. States have the right to administrative and judicial review.

The Committee bill would prohibit the Secretary from taking any disallowance, penalty, compliance, or other action to recover Federal matching funds paid to a State solely because the expenditures on which the matching funds were based were paid for with revenues derived from voluntary contributions, provider-specific taxes, or intergovernmental transfers. In the case of expenditures attributable to contributions or taxes, this prohibition would apply with respect to the calendar quarters beginning January 1, 1992, and ending September 30, 1992; in the case of expenditures attributable to voluntary contributions, with respect to calendar quarters beginning January 1, 1992, and ending December 31, 1992.

The purpose of these moratoria is to protect the States from Federal administrative actions that would result in a reduction in Federal Medicaid matching funds—whether prospective or retroac-

tive—on the grounds that the States would be in violation of a regulation (such as the October 31 interim final rule) that is subject to the regulatory moratorium imposed under this bill. The Committee emphasizes that the Secretary does not have the authority to circumvent the regulatory moratorium through estimation, disallowance, or other administrative procedures.

REPORT (SECTION 4)

The committee bill does not amend or otherwise alter the statutory language enacted in OBRA '90, and codified at sections 1902(t) and 1903(i)(10) of the Social Security Act, that sets forth current Federal policy regarding the use of provider-specific taxes. The Committee stresses that, under current law, with one narrow exception, States may, effective January 1, 1991, use the revenues from provider-specific taxes to fund their share of Medicaid expenditures with full Federal financial participation. The Committee recognizes that the Administration has expressed a concern about the proliferation of provider-specific tax arrangements, and perhaps for that reason has created its own statutory policy on this matter. The Committee appreciates the Administration's concern and is willing to consider proposals from the Administration for changes in current law. However, the Committee insists that these changes, where warranted, be effected through the normal legislative process, not by regulation.

Thus, in addition to imposing a moratorium on the implementation of HCFA's October 31 rule, the bill would direct the Secretary to submit to the Committee on Energy and Commerce and the Senate Committee on Finance a report describing (1) any regulation the Secretary intends to issue to limit the use of donations or provider-specific taxes, (2) the specific types of donations and provider-specific taxes that may be used under the regulation as a source of a State's Medicaid expenditures for which Federal matching funds are available, and (3) any legislation the Secretary believes is appropriate. To give the Committee and the Congress sufficient time to consider any legislative proposals, the bill requires that the report be submitted by not later than February 3, 1992 (the date the President's FY 93 budget must be submitted to the Congress).

BUDGET COMPLIANCE PROVISIONS (SECTION 5)

(a) Cost estimate

In compliance with clause 8 of Rule XXI of the Rules of the House of Representatives, the bill states that the applicable cost estimate of this Act for all purposes of section 252 and 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 shall be as follows: for each of fiscal years 1991 through 1995, the increase in outlays is 0 and the increase in receipts is 0. This is the formal estimate of the Congressional Budget Office, which appears in its entirety elsewhere in this Committee report.

(b) Treatment under pay-as-you-go procedures

Under the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Enforcement Act of 1990, any

legislated increases in mandatory spending must be offset by some combination of increases in revenue or reductions in other mandatory spending. If no such offset is enacted, then a sequester of non-exempt mandatory spending will occur 15 days after Congress adjourns at the end of each session. Under this sequestration, reductions are imposed on all non-exempt mandatory spending programs. The reduction in Medicare provider reimbursement is limited to 4 percent, but because Medicare is so large relative to other non-exempt mandatory spending, it would absorb over 80 percent of the total sequestration cuts. Other non-exempt mandatory spending programs that would be subject to sequestration include vocational rehabilitation, guaranteed student loans, farm price supports, child support enforcement, and veterans' burial benefits.

The bill provides that, notwithstanding the CBO cost estimate set forth above, the amendments made by the bill shall be treated as provisions designated as emergency requirements by the President and the Congress under section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. The bill further provides that any amount of new budget authority or outlays resulting from the amendments it makes shall not be considered for any purpose under the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. The purpose of these two provisions is to assure that, under the pay-as-you-go enforcement procedures, if the Office of Management and Budget disregards the estimates of the Congressional Budget Office and estimates that this bill would increase outlays in FY 1992 or any other year, the OMB estimate will not be included in the calculation of any deficit increase, and this bill will not otherwise trigger sequestration.

COMMITTEE VIEWS RELATING TO PARTICULAR STATES

In meeting the statutory requirements relating to payments to disproportionate share hospitals, New York operates under a special statutory rule enacted in 1987 and set forth at section 1923(a)(1)(A)(i) of the Social Security Act. The Committee knows that these payments involved provider-specific taxes and pooling arrangements. In 1991, the State increased its disproportionate share payments to a subset of hospitals serving very high levels of low-income patients (i.e., 35 percent or more Medicaid admissions). Qualifying hospitals receive disproportionate share payment adjustments that are increased on a sliding scale basis to a level of up to 90 percent of the cost of services to the uninsured. Localities assume 100 percent of the non-Federal share of the cost of supplemental disproportionate share payment adjustments made to qualifying public facilities. The Committee is informed that the October 21 HCFA regulation, if implemented, could eliminate or substantially reduce Federal funding for these supplemental payments by treating them as an inappropriate intergovernmental transfer. The Committee wishes to emphasize that nothing in the current Medicaid statute, including the provider-specific tax provisions at section 1902(t) and 1903(i)(10) of the Act, authorizes the Secretary to deny or limit Federal Medicaid matching funds to New York for the supplemental disproportionate share payment adjustments it makes to

qualified hospitals delivering covered services to eligible individuals.

CONCLUDING OBSERVATIONS

Some of our colleagues have argued that State provider tax and donation programs are "wrong and morally corrupt." The Committee acknowledges that the voluntary contribution arrangements in some States may not represent ideal public policy. However, the Committee would note that States are not operating under ideal economic circumstances; instead, many are struggling to meet the growing demands for basic medical care and long-term care services for their most vulnerable citizens. The Committee, in OBRA '90, agreed to phase out the use of revenues from provider donations on the understanding that States would have a reasonable period of transition. Unfortunately, the Administration's evident determination to implement the October 31st regulation would prevent States from using revenues for provider-specific taxes which are specifically permitted under current law as well, leaving this Committee—and the Congress—with no real alternative at this late date but to enact this bill in order to avoid fiscal and programmatic chaos in many States less than two months from now.

During the Committee's deliberations on this legislation, some Members argued that the decision of States to rely on revenues from voluntary contributions, provider taxes, or intergovernmental transfers is a result of the expansion of coverage and other improvements in the Medicaid program which this Committee has authored over the last 7 years or so. It is, they contend, a case of "chickens coming home to roost" as the result of "mandate madness."

Our colleagues are correct that the Committee has made efforts to reduce infant mortality by expanding Medicaid coverage for prenatal and maternity care for low-income pregnant women and infants. They are correct that the Committee has attempted to improve child health by phasing in, over the next 10 years, Medicaid coverage for all children under the Federal poverty level, and by improving the early and periodic screening, diagnosis, and treatment (EPSDT) benefit for children. They are correct that the Committee has endeavored to improve the quality of care and the quality of life for the elderly in nursing facilities. They are correct that the committee has tried to protect the community spouses of nursing facility residents from impoverishment. They are correct that the Committee has attempted to target additional resources to hospitals of last resort who serve disproportionately large numbers of Medicaid-eligible and uninsured patients. And they are correct that the Committee has attempted to protect low-income elderly and disabled Medicare beneficiaries from the cost burden of increased Medicare premiums, deductibles, and coinsurance. The Committee is proud of policy initiatives it has taken to improve the health status of poor Americans.

Our colleagues are incorrect, however, in their contention that the Medicaid cost pressures on the States are primarily attributable to these program improvements. Even if the Committee were to repeal all of these improvements in this bill, the States would still

be facing most of the cost increases that they face now, as the following analysis by the Congressional Budget Office makes clear:

"Medicaid is experiencing pressures from many of the same sources that have fueled growth in the Federal government's Medicare program. These include high medical care inflation, which is well above the general rate of inflation, and greater intensity of services (such as the use of new drugs, technologies, and procedures). Recent legislation to expand eligibility, upgrade the standard of care in nursing homes, and raise 'disproportionate share' payments (paid to hospitals that serve an unusually large share of Medicaid enrollees) cost money. And the recession has swollen enrollment." CBO, "The Economic and Budget Outlook: An Update" (August, 1991) at 53.

The CBO analysis shows that most of the increase in Medicaid costs is attributable to factors other than program improvements, primarily health care inflation, increases in the use of services (prompted in part by the AIDS and drug epidemics), and growth in the number of poor and unemployed people. To respond to these developments, States will need more resources. The October 31 regulation will illegally and drastically undermine the ability of States to raise revenues from the health care sector of their economies—a sector which, in many States, is one of the few displaying any significant growth. To deny the States the ability to tax health care providers will aggravate the Medicaid cost crisis, not solve it. The consequences for the health of our nation's poor are unacceptable.

HEARINGS

The Committee's Subcommittee on Health and the Environment held two hearings on the subject of State financing of Medicaid through provider-specific taxes and intergovernmental transfers, focusing on the impact of the interim final regulation issued by the Health Care Financing Administration on September 12, 1991. At the first hearing, held on September 30, 1991, the Subcommittee heard testimony from Members of Congress, the Governors of the States of Kentucky and Oklahoma, and State and local officials describing the impact of the September 12 regulation. At the second hearing, held on October 16, 1991, the Subcommittee heard testimony from the House Majority Leader, other Members, and the Administrator of the Health Care Financing Administration.

COMMITTEE CONSIDERATION

The bill H.R. 3595, the Medicaid Moratorium Amendments of 1991, was introduced on October 21, 1991, by Chairman Waxman, Chairman Dingell, the House Majority Leader, Chairman Rostenkowski, 12 Members of the Subcommittee on Health and the Environment, and 18 other Members. It was referred exclusively to the Committee on Energy and Commerce.

On October 23, 1991, the Subcommittee on Health and the Environment met in open session and ordered reported the bill, H.R. 3595, without amendment, by a roll call vote of 16 to 6, a quorum being present.

On November 7, 1991, the Committee met in open session and ordered reported the bill, H.R. 3595, with amendments, by a roll call vote of 36-7, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Subcommittee on Health and the Environment held oversight hearings and made findings that are reflected in the legislative report.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of Rule XI of the Rules of the House of Representatives, no oversight findings on this subject have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee agrees with the Congressional Budget Office that no cost would be incurred by the Federal Government in carrying out H.R. 3595.

This legislation would prohibit the Secretary of Health and Human Services from implementing regulations, or taking certain administrative actions, that would have the effect of altering current policy with respect to State use of revenues from voluntary contributions, provider-specific taxes, and intergovernmental transfers to finance the State share of the Medicaid program. Since this bill would simply maintain current policy, it would, under long-established conventions regarding the estimation of legislative proposals, have no cost to the Federal government. Conversely, any change in current policy that would disallow the use of voluntary contributions, provider-specific taxes, or intergovernmental transfers would result in savings to the Federal government.

This appears to have been the position of the Department of Health and Human Services when, in February of 1991, it submitted to the Committee on Appropriations its "Justification of Appropriations Estimates for Fiscal Year 1992" relating to programs administered by the Health Care Financing Administration. At page 21 of this document, the Department stated that "A number of Medicaid initiatives are included in the budget." One of these is the regulation issued on September 12, 1991, then "clarified" on October 31, 1991, which the Department explained as follows: "This HCFA regulatory initiative will address the use of donations and provider-specific taxes as the State share of Medicaid. The objective of the rule is to ensure that State oversight responsibilities are not compromised by such arrangements and that State expenditures are properly matched. Estimated savings are \$80 million in FY 1992."

On October 8, 1991, the Chairman of the Subcommittee on Health and the Environment wrote to the Director of the Office of Management and Budget to request an estimate of the cost of legislation prohibiting the implementation of the September 12 regulation during FY 1992 (the October 31 "clarification" had not at that point been issued). No response to this request, written or oral, has been forthcoming.

CONGRESSIONAL BUDGET OFFICE ESTIMATE,

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 12, 1991.

Hon. JOHN DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has reviewed H.R. 3595, as ordered reported by the Committee on Energy and Commerce on November 7, 1991. H.R. 3595 would require the Secretary of Health and Human Services to wait until after September 30, 1992 to issue regulations changing the treatment of certain voluntary contributions and provider-specific taxes in the Medicaid program. These voluntary contributions and provider-specific taxes are used by states as a source of state expenditures for which federal financial participation (FFP) is available under the Medicaid program. H.R. 3595 also would maintain the treatment of intergovernmental transfers as a source of state Medicaid funding. Finally, the bill would delay the enforcement of any regulation changing the treatment of voluntary contributions until January 1, 1993, except the FFP provided to any state for voluntary contributions would be limited to the amount of FFP that resulted from the state's use of voluntary contributions in fiscal year 1991.

This legislation does not affect receipts and would not change Medicaid outlays from the amount assumed in the CBO baseline. Therefore, the bill would not affect the federal budget relative to CBO's baseline. As a result, there are no pay-as-you-go effects under the Budget Enforcement Act of 1990. Finally, there would be no effect on the level of state and local spending for the Medicaid program. State and local governments could continue to use all of the sources of funds for their share of Medicaid spending that are allowed under current law.

The CBO baseline assumes the continuation of current law, under which voluntary contributions and provider-specific taxes are allowed as part of the state share of Medicaid financing and under which there is a moratorium on regulations limiting the use of voluntary contributions and provider-specific taxes lasting through the end of calendar year 1991. Nevertheless, while current law allows the Secretary of Health and Human Services to issue regulations with respect to voluntary contributions and provider-specific taxes after December 31, 1991, the CBO baseline does not incorporate regulations that were not final at the time the baseline was prepared.

The provisions of H.R. 3595 that relate to provider-specific taxes have no cost relative to the CBO baseline they continue the moratorium, assumed in the baseline, on regulations limiting the use of such taxes for the Medicaid program. The provisions relating to state use of voluntary contributions also have no cost relative to the CBO baseline. In the latter case, however, the reason is that the bill caps the amount of FFP for such contributions after September 30, 1992 at the amount of FFP the state received for voluntary contributions in fiscal year 1991. Although the CBO baseline

for Medicaid was developed assuming a one-year moratorium on regulations limiting FFP for state financing from these sources, the baseline also assumed that in any year the limited duration of this moratorium would act as a constraint on the use of these sources of financing by the states. Extending the moratorium on regulations beyond one year would lessen a constraint that has dissuaded some states from using these sources of financing to their full potential. An extension of the moratorium beyond one year could induce states to expand their use of voluntary contributions and provider-specific taxes over the amount assumed in the baseline, unless the use of these sources of financing were to be capped, as in this bill, at a level that had been reached before the moratorium on regulations was lengthened.

As stated above, because the bill would not change spending or receipts from the amount assumed in its baseline, CBO finds no pay-as-you-go implications to H.R. 3595. In addition, section 5(b) of the bill declares that its provisions shall be treated as emergency requirements as designated by the President and Congress under section 252(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 and that any new outlays resulting from the bill shall not be considered for any purpose under the Balance Budget and Emergency Deficit Control Act of 1985.

If you would like further details on this estimate, we would be pleased to provide them. The CBO staff contact is Patrick Purcell, who can be reached at 226-2820.

Sincerely,

ROBERT D. REISCHAUER,
Director.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the enactment of this bill into law will not have an inflationary impact on prices and costs in the operation of the national economy. The effect of this legislation is to allow the States to continue to fund their Medicaid programs as they are funding them under current law: by using revenues from voluntary contributions, provider-specific taxes, and intergovernmental transfers to pay the State share of program expenditures. The bill does not expand eligibility for the program, does not expand the services that the program would cover, and does not increase the levels at which States are permitted to reimburse providers for delivering covered services.

AGENCY VIEWS

SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, October 30, 1991.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: We take this opportunity to inform you of the Department's view on H.R. 3595, a bill pending before the com-

mittee. We strongly oppose this legislation. If it were presented to the President, his senior advisers would recommend a veto.

The bill would extend to September 30, 1992, the moratorium on Medicaid regulations pertaining to provider-specific taxes and voluntary contributions that will otherwise expire as of January 1, 1992. The moratorium would also be broadened to preclude any regulation on these issues, rather than barring only final regulations, as does current law. H.R. 3595 would also allow voluntary contributions to be used as the State share for Medicaid until December 31, 1992, but would limit the total amount of those contributions in FY 1993 to an amount equal to the FY 1991 total. A new and permanent moratorium would be applied to any regulation changing the treatment of transfers of funds among governmental entities within the State. In addition, H.R. 3595 would require the Secretary of Health and Human Services (HHS) to submit a report to Congress by February 3, 1992, describing future regulations and legislative initiatives pertaining to voluntary contributions or provider taxes. H.R. 3595 would require that the pay-as-you-go costs of the bill be treated as emergency requirements and not be counted for purposes of the Budget Enforcement Act of 1990 (BEA).

We strongly oppose the moratoriums that would be imposed by H.R. 3593, for several reasons. First, the moratorium on voluntary contributions and provider taxes has already been extended twice. Initially, this moratorium was scheduled to expire on May 1, 1989. Most recently, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) extended the moratorium to December 31, 1991. The Congress and the States have been on notice since at least 1988 that the Federal Government was planning to act in this area. Yet the Congress has twice extended the moratorium, declaring that more time is needed to examine the issue. During this time many more States have adopted these provider tax and contributions programs.

In the year since OBRA 90 was enacted, the number of States with provider-specific taxes, provider contribution programs, or both skyrocketed from 9 to 39. Another 6 States are now considering using these programs to increase the Federal share of Medicaid. There is no limit on the amount of additional Federal dollars that these funding strategies can generate. One year ago, the Department's Inspector General (IG) estimated that provider tax and voluntary contribution programs were generating \$497 million per year in Federal funding for the States. Today the IG estimates that these types of funding mechanisms will generate at least \$5.5 billion in Federal costs for FY 1992, adding to the Federal deficit. The bill not only increases the deficit, but prohibits the added costs from being counted under the pay-as-you-go provisions of the BEA. In addition, the bill includes a "directed scorekeeping" provision that specifies the dollar amounts that are to be used in estimating costs under the bill. The President has stated previously that he would veto any legislation that contained such a provision.

We know that last year's moratorium resulted in at least a tenfold increase in Federal funding associated with States' use of provider tax and contribution programs. Many more billions of dollars would be spent under another moratorium. State provider tax and voluntary contribution programs threaten to alter fundamentally

the existing principles of the Medicaid funding partnership between Federal and State governments. These financing programs could potentially result in Federal payments to States of 100 percent, or even more than 100 percent, of the costs of the Medicaid program. Enactment of H.R. 3595 would result in out-of-control Federal Medicaid spending for yet another nine months.

A permanent moratorium on changing the treatment of intergovernmental transfers would be unnecessary. On September 12, 1991, the Department's Health Care Financing Administration published an Interim Final Rule interpreting the OBRA 90 provider tax provisions and prohibiting the use of provider donations. Unfortunately, this rule has caused some confusion, particularly with regard to the treatment of intergovernmental transfers as the State share of Medicaid. A clarification of this rule will be published in the Federal Register on October 31, 1991. This clarification explicitly states that HCFA is not eliminating the use of traditional intergovernmental transfers in Medicaid. Under this regulation, public funds transferred between different levels of local government will continue to be matched by the Federal Government; however, provider taxes and donations generated at the local level will be viewed in the same manner as State-generated provider taxes and donations for the purpose of Federal matching funds.

In a Federal-State matching program, it is imperative that those responsible for the direct fiscal management of the program have a reasonable stake in program costs. The requirement for a State share of Medicaid has always acted as a restraint on the otherwise open-ended Federal spending. Without a limit on evolving State donation and tax programs, we would move quickly toward a system of fourth party payment where the Federal government, not the patient, the provider, or the State as a manager of the program, was at risk for the cost of services.

State donation and tax programs, if unchecked, will undermine a basic premise of the Medicaid program—that States have a stake in the costs. We are willing to discuss with the Congress legislative alternatives to our rule, but any compromise must protect the integrity of the Medicaid program and the Federal treasury. We cannot condone the alteration of the Medicaid program through financing mechanisms that go beyond the conventional matching rate structure. States are accountable for the appropriate management and financing of their programs and the Federal government is responsible for holding them accountable.

For the foregoing reasons, the Department recommends that H.R. 3595 not be favorably considered.

The Office of Management and Budget has advised that there is no objection to the presentation of this report and that the enactment of H.R. 3595 would not be in accord with the program of the President.

Sincerely,

LOUIS W. SULLIVAN, M.D.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill,

as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law, in which no change is proposed, is shown in roman):

SECTION 8431 OF THE TECHNICAL AND MISCELLANEOUS REVENUE ACT
OF 1988

SEC. 8431. DELAY IN ISSUANCE OF [FINAL] REGULATIONS CONCERNING
THE USE OF VOLUNTARY CONTRIBUTIONS AND PROVIDER
PAID TAXES BY STATES TO RECEIVE FEDERAL MATCHING
FUNDS.

(a) *IN GENERAL.*—The Secretary of Health and Human Services shall not issue any [final regulation prior to December 31, 1991] *regulation prior to October 1, 1992*, changing the treatment of voluntary contributions or provider-paid taxes utilized by States to receive Federal matching funds under title XIX of the Social Security Act.

(b) *MAINTAINING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.*—*The Secretary shall not issue any regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, including the treatment of such funds as a source of State share of financial participation under such title regardless of whether the public agency contributing the funds provides services under the State plan, under such title.*

(c) *TRANSITION FOR VOLUNTARY CONTRIBUTIONS.*—*Any regulation that changes the treatment of voluntary contributions utilized by States to receive Federal matching funds under title XIX of the social Security Act shall not apply to voluntary contributions made before January 1, 1993, except that, with respect to a State, the amount of Federal financial participation during fiscal year 1993 that results from the State's use of voluntary contributions under such title may not exceed the amount of Federal financial participation during fiscal year 1991 that resulted from the State's use of voluntary contributions.*

(d) *MORATORIUM ON REVISIONS OF ESTIMATED AMOUNTS.*—

(1) *IN GENERAL.*—*In estimating the amount to which a State will be entitled for a quarter under subsections (a) and (b) of section 1903 of the Social Security Act under section 1903(d)(1) of such Act, the Secretary may not withhold any amounts estimated to be expended during the quarter (or reduce any amount so estimated pursuant to section 1903(d)(2)(A) of such Act) solely because the amounts are attributable to voluntary contributions, intergovernmental transfers, or provider-paid taxes.*

(2) *PERIOD OF APPLICABILITY.*—*Paragraph (1) shall apply—*

(A) *in the case of amounts attributable to intergovernmental transfers or provider-paid taxes, with respect to quarters beginning on or after January 1, 1992, and ending on or before September 30, 1992; and*

(B) *in the case of amounts attributable to voluntary contributions, with respect to quarters beginning on or after January 1, 1992, and ending on or before December 31, 1992.*

(e) *MORATORIUM ON PENALTIES AND OTHER REGULATORY ACTIONS.*—

(1) *IN GENERAL.*—*The Secretary may not assess a penalty or take any compliance, disallowance, or other regulatory action against a State under or pursuant to title XIX of the Social Security Act on the basis of the State's use of voluntary contributions, intergovernmental transfers, or taxes (whether or not of general applicability) paid by, assessed against, or received from an individual or entity providing medical assistance under the State plan under such title to receive Federal matching funds under such title.*

(2) *PERIOD OF APPLICABILITY.*—*Paragraph (1) shall apply with respect to actions taken by the Secretary—*

(A) on the basis of a State's use of intergovernmental transfers or taxes during the period beginning on or after January 1, 1992, and ending on or before September 30, 1992; and

(B) on the basis of a State's use of voluntary contributions during the period beginning on or after January 1, 1992, and ending on or before December 31, 1992.

DISSENTING VIEWS ON H.R. 3595, MEDICAID MORATORIUM AMENDMENTS

H.R. 3595, the Medicaid Moratorium Amendments of 1991, is a deeply flawed bill. Not only does it allow States to use what the Health and Human Services (HHS) Inspector General has called fiscal scams to finance their Medicaid programs for another year, but it also breaks the 1990 Budget Agreement to pay for it. Consequently, we strongly oppose this bill.

The issue of provider-specific taxes and voluntary donations is a complex issue with many facets. We believe, though, that these financial mechanisms have the potential to undermine a basic tenet of the Medicaid program, which is that funding be shared through a match of State monies. In the Medicaid program, the States, which are responsible for expenditure decisions and the direct fiscal management of the program, must have a reasonable stake in program costs. This shared financial responsibility between the Federal government and the States works to shape their decision-making so as to contain health care costs. The requirement for a State share of payment has always acted as a critical restraint on the otherwise open-ended Medicaid program.

Now we are in a situation where State provider tax and donation programs threaten to alter fundamentally the intended funding relationship between Federal and State governments. Without a limit on evolving State donation and tax programs, we will move quickly toward a 100 percent Federally-funded program.

The Inspector General has reported on the exponential growth of these programs. Estimates of Federal funds being requested by States to match donations and taxes illustrate the rapid growth of these programs. In October, 1990, the Inspector General reported that \$497 million in matching funds was requested by 9 States. By May of 1991, 18 States had requested \$2.5 billion—five times the amount requested just over a half a year earlier. By July, 1991, 30 States had requested \$3.8 billion in Federal funds.

Unless restrained, the growth in Federal funds for State donations and provider-specific taxes is not expected to abate. The Health Care Financing Administration (HCFA) estimates that States will request at least \$5.5 billion in Federal funds in Fiscal Year 1992.

Although some States are using these "free" Federal funds to increase services and make other positive changes, nothing under current law even allows HCFA to ensure that "free" Federal funds are used in this manner. On the other hand, the Inspector General reported that "provider tax and donation programs are generally not about increasing services to Medicaid recipients, nor are they about improving the quality of care provided to Medicaid recipients. They are, in our opinion, carefully crafted creative financing techniques that allow States to reduce their share of Medicaid costs

and force the Federal Government to pay significantly more.” (The Use of Medicaid Provider Tax and Donation Programs Needs to be Controlled”, (Office of Inspector General (A-03-91-00203), July 1991, p. 2).’

These fiscal numbers are truly disturbing. But even worse is the fact that everyone involved—the Federal Government, the States, and the providers—knows that these financing schemes are wrong and morally corrupt. It is “blue smoke and mirrors” masquerading as a valid means of financing health care. Or worst yet, this is nothing more than voodoo health care economics.

If these arrangements are allowed to continue, a significant shift in the intended, shared relationship of Federal and State responsibility will occur. In addition, States that choose not to engage in tax and donation programs are disadvantaged relative to other States. Their citizens feel the negative effects that increased Federal outlays associated with donation and tax programs cause, without the benefit of those dollars flowing to their States.

The following excerpts from the July, 1991 Inspector General’s Report reveal the uneasiness of participants in these programs (“The Use of Medicaid Provider Tax and Donation Programs Needs to be Controlled” (A-03-91-002031)):

(1) Perhaps an unnamed State legislative staffer best summed up the States’ attitude toward provider programs when, in referring to his State’s legislators, he was quoted as saying “At first, legislative leaders were calling it a *scam*, they then began calling it a *scheme*, and now they are referring to it as a *funding mechanism*.” (p. 2)

(2) In referring to this tax program, the State Commissioner of Health and Human Services of New Hampshire was quoted as saying that, “until very recently I have not been at all happy—and I’m still not really enthusiastic—about what is a legal but I think might be a questionable method of taking money away from the Federal Government * * *.” (pp. 7-8)

(3) One physician complained to the Office of the Inspector General that Maryland “might have been committing fraudulent acts by reporting untrue amount payments made to health care providers to the Federal Government in order to get much more Federal reimbursements than it actually pays to health care providers * * * [Y]our prompt investigation of the scheme will be a great service to all taxpayers of this country.” (p. 11)

Although donation and tax programs vary from State to State, they all alter the Medicaid matching rate in basically the same way. These programs typically work as follows: (1) States “borrow” money from providers (usually hospitals) through donations or tax programs; (2) this money is then used as the State share of Medicaid and is matched, at least dollar for dollar, by Federal funds; (3) States frequently increase Medicaid payments to reimburse providers for the donations or taxes they paid; and (4) then States use the Federal matching funds to pay providers for the Medicaid services. In many States, providers are guaranteed to get back at least as much as they donated or paid in provider-specific taxes through enhanced Medicaid reimbursements.

An illustrative example is a situation described by Dr. Gail Wilensky, HCFA Administrator, in her October 16, 1991, testimony to

the Subcommittee on Health and the Environment of this Committee. Suppose hospitals are being paid \$100 million under Medicaid. Assuming that the match rate is 50%, the State and the Federal government would each pay \$50 million. The State then both: (1) implements a tax or donation program and receives \$100 million from hospitals; and (2) increases the payment to the hospitals to \$200 million. Under this scenario, hospitals are actually getting the same net payment of \$100 million after deducting the cost of the donation or tax, but this \$100 million is 100 percent Federal money. Before the financial scheme, the State paid 50 percent of the provider payment, or \$50 million. Now the State pays nothing. In this example, the Federal matching payment has gone from a nominal 50% to an effective 100%.

This example shows why our State capitols are now being besieged by hospital lobbyists asking State legislators to place new taxes on their revenues. Hospital associations, nursing homes, and other providers are begging the legislators to place new taxes on their institutions. We ask our colleagues who voted for this bill—Does something smell funny?

Additionally, have any of our colleagues ever heard of hospitals getting together for the purposes of borrowing hundreds of millions of dollars and then contributing that money to the State in the form of a charitable contribution? That is exactly what is occurring now in many States.

Finally, we would like to ask our colleagues this. If the Federal government taxed you \$1,000 on Tuesday, and on Wednesday you received a check back for \$1,200 from the government, would you call that a "tax" or a profitable investment? We know what we would call it—a profitable investment. And this is exactly how the more ingenious provider-tax schemes work. And it is exactly why providers are suddenly insisting that they be "taxed."

Obviously, something is very wrong here. And clearly, HCFA, OMB, and the Inspector General should be concerned. And so should Congress. This statement from the May 10, 1991, Inspector General's Report (States Increase Their Use of Revenues Generated by Provider Tax and Donation Programs as the States' Share of Medicaid Expenditures (A-14-91-01010)) explains the need for concern:

The growth of provider tax and donation programs is almost like a virus spreading from State to State. Conceivably, the Federal Government could ultimately be required to bear a disproportionate share of the entire cost of the Medicaid program, unless the "loopholes" are closed. (p.1)

For the above listed reasons, we strongly oppose this bill and we urge our colleagues to do likewise.

NORMAN F. LENT.
BILL DANNEMEYER.
THOMAS J. BLILEY.
MICHAEL BILIRAKIS.
ALEX McMILLAN.
CLYDE C. HOLLOWAY.

MEDICAID MORATORIUM AMENDMENTS OF 1991

NOVEMBER 27 (legislative day, NOVEMBER 26), 1991.—Ordered to be printed

Mr. DINGELL, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3595]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3595), to delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991".

SEC. 2. PROHIBITION ON USE OF VOLUNTARY CONTRIBUTIONS, AND LIMITATION ON THE USE OF PROVIDER-SPECIFIC TAXES TO OBTAIN FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.

(a) *IN GENERAL.*—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end of the following new subsection:

"(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any

fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

“(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

“(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

“(II) donations described in paragraph (2)(C);

“(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

“(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

“(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

“(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

“(C)(i) Except as otherwise provided in clause (ii) subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

“(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

“(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

“(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

"(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(iii) In this subparagraph and subparagraph (E), the term 'impermissible tax' means a health care related tax for which a reduction may be made under clause (ii) or (iii) subparagraph (A).

"(E)(i) In no case may the total amount of donations and taxed permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

"(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

"(F) In this paragraph in the case of a State—

"(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

"(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

"(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

"(2)(A) In this subsection (except as provided in paragraph (6)), the term 'provider-related donation' means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

"(i) a health care provider (as defined in paragraph (7)(B)),

"(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

"(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraphs (2), (3), (4), (6), or (7) of subsection (a).

"(B) For purposes of paragraph (1)(A)(i)(I), the term 'bona fide provider-related donation' means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

"(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (included costs of training and of preparing and distributing outreach materials) of State or local agency

personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

“(3)(A) In this subsection (except as provided in paragraph (6)), the term ‘health care related tax’ means a tax (as defined in paragraph (7)(F) that—

“(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

“(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 35 percent of the burden of such tax falls on health care providers.

“(B) In this subsection, the term ‘broad-based health care related tax’ means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) and (E)—

“(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

“(ii) is imposed uniformly (in accordance with subparagraph (C)).

“(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

“(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

“(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed or each provider of such items or services in the class;

“(III) in the case of a tax based on revenues or receipts with respect to a class or items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

"(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

"(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or providers for a holdharmless provision described in paragraph (4).

"(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

"(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

"(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

"(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers or such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraphs (B) and (C). Permissible waivers may include exemptions for rural or sole-community providers.

"(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

"(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

"(II) the amount of the tax is not directly cor-related to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

"(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

"(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

"(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

"(C) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or

waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

"(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

"(B)(i) In subparagraph (A), the term 'State base percentage' means, with respect to a State, an amount (expressed as a percentage) equal to—

"(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

"(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

"(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

"(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

"(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

"(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

"(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

"(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

"(7) For purposes of this subsection:

"(A) Each of the following shall be considered a separate class of health care items and services:

"(i) Inpatient hospital services.

"(ii) Outpatient hospital services.

"(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

"(iv) Services of intermediate care facilities for the mentally retarded.

"(v) Physicians' services.

"(vi) Home health care services.

"(vii) Outpatient prescription drugs.

"(viii) Services of health maintenance organizations (and other organizations with contracts under section 1903(m)).

"(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

"(B) The term 'health care provider' means an individual or person that receives payments for the provision of health care items or services.

"(C) An entity is considered to be 'related' to a health care provider if the entity—

"(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

"(ii) is a person with an ownership or control interest as defined in section 1124(a)(3) in the provider;

"(iii) is the employee, spouse, parent, child or sibling of the provider (or of a person described in clause (ii)); or

"(iv) has a similar, close relationship (as defined in regulations) to the provider.

"(D) The term 'State' means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

"(E) The 'State fiscal year' means, with respect to a specified year, a State fiscal year ending in that specified year.

"(F) The term 'tax' includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

"(G) The term 'unit of local government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State."

(b) CONFORMING AMENDMENTS.—(1) Section 1902(t) of such Act (42 U.S.C. 1396a(t)) is amended—

(A) by striking "Except as provided in section 1903(i), nothing" and inserting "Nothing", and

(B) by striking "taxes (whether or not of general applicability)" and inserting "taxes of general applicability".

(2) Section 1903(i) of such Act (42 U.S.C. 1396(i)) is amended by striking paragraph (10) inserted by section 4701(b)(2)(B) of the Omnibus Budget Reconciliation Act of 1990.

(c) **EFFECTIVE DATE.**—(1) The amendments made by this section shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date.

(2) Except as specifically provided in section 1903(w) of the Social Security Act and notwithstanding any other provision of such Act, the Secretary of Health and Human Services shall not, with respect to expenditures prior to the effective date specified in section 1903(w)(1)(F) of such Act, disallow any claim submitted by a State for, or otherwise withhold Federal financial participation with respect to, amounts expended for medical assistance under title XIX of the Social Security Act by reason of the fact that the source of the funds used to constitute the non-Federal share of such expenditures is a tax imposed on, or a donation received from, a health care provider, or on the ground that the amount of any donation or tax proceeds must be credited against the amount of the expenditure.

(3) The interim final rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56132), relating to the State share of financial participation under the medicaid program, is hereby nullified and is of no effect. No part of such rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 3. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS.

(a) **REPEAL OF PROHIBITION OF UPPER PAYMENT LIMIT FOR DISPROPORTIONATE SHARE HOSPITALS.**—Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)) is amended by striking “to limit” the first place it appears and all that follows through “special needs or”.

(b) **LIMITATION ON AGGREGATE PAYMENT ADJUSTMENTS.**—

(1) **IN GENERAL.**—Section 1923 of such Act (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

“(f) **DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.**—

“(1) **IN GENERAL.**—

“(A) **APPLICATION OF STATE-SPECIFIC LIMITS.**—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

“(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

“(I) the payment adjustments are made—

“(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991,

“(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification

thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

“(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

“(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

“(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as ‘DSH’) allotment for the year (as specified in paragraph (2)).

“(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

“(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

“(i) the national DSH payment limit for the fiscal year, and

“(ii) the State DSH allotment for each State for the year.

“(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

“(i) The hospital’s medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

“(ii) the hospital’s low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

“(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is equal to at least 1 percent of the total number of such days for all hospitals in the State.

“(iv) The hospital meets such alternative requirement as the Secretary may establish by regulation, taking into account the special circumstances of children’s hospitals, hospitals located in rural areas, and sole community hospitals.

“(E) *CONDITION FOR OPTION.*—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a State exercising such option.

“(2) *DETERMINATION OF STATE DSH ALLOTMENTS.*—

“(A) *IN GENERAL.*—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

“(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

“(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

“(B) *EXCEPTIONS.*—

“(i) *LIMIT TO 12 PERCENT OR BASE ALLOTMENT.*—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State base allotment.

“(ii) *EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.*—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

“(3) *STATE SUPPLEMENTAL AMOUNTS.*—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

“(A) *DETERMINATION OF REDISTRIBUTION POOL.*—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

“(i) the total of the State base allotments for high DSH States;

“(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

“(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal year; and

“(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

“(B) *DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.*—The supplemental amount for a State for a fiscal year is equal to the lesser of—

“(i) the product of the amount determined under subparagraph (A) and the ratio of—

“(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

“(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year,
or

“(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

“(4) DEFINITIONS.—In this subsection:

“(A) HIGH DSH STATE.—The term ‘high DSH State’ means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

“(B) STATE.—The term ‘State’ means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

“(C) STATE BASE ALLOTMENT.—The term ‘State base allotment’ means, with respect to a State, the greater of—

“(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

“(ii) \$1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

“(D) STATE GROWTH AMOUNT.—The term ‘State growth amount’ means, with respect to a State for a fiscal year, the lesser of—

“(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year,
or

“(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

“(E) STATE GROWTH FACTOR.—The term ‘State growth factor’ means, for a State for a fiscal year, the percentage by which the expenditures described in section 1903(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year.”

(2) CONFORMING AMENDMENTS.—(A) Such section 1923 is further amended—

- (i) in subsection (a)(2)(B), by striking "subsection (c)," and inserting "subsections (c) and (f)," and
- (ii) in subsection (c), by striking "In order" and inserting "Subject to subsection (f), in order".

(B) Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting "and section 1923(f)" after "of this section".

(c) **LIMITS ON AUTHORITY TO RESTRICT DSH DESIGNATIONS.**—Subsection (b) of such section is amended by adding at the end the following new paragraph:

"(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4)."

(d) **STUDY OF DSH PAYMENT ADJUSTMENTS.**—

(1) **IN GENERAL.**—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) **ITEMS INCLUDED IN STUDY.**—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) **REPORT.**—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

(e) **EFFECTIVE DATE.**—(1) The amendments made by this section shall take effect January 1, 1992.

(2) The proposed rule promulgated by the Secretary of Health and Human Services on October 31, 1991 (56 Federal Register 56141), relating to the standards for defining disproportionate share hospitals under the medicaid program, shall be withdrawn and canceled. No part of such proposed rule shall be effective except pursuant to a rule promulgated after the date of the enactment of this Act and consistent with this section (and the amendments made by this section).

SEC. 4. REPORTING REQUIREMENT.

(a) *IN GENERAL.*—Section 1903(d) of the Social Security Act (42 U.S.C. 1396b(d)) is amended by adding at the end the following:

“(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

“(i) provider-related donations made to the State or units of local government during such fiscal year, and

“(ii) health care related taxes collected by the State or such units during such fiscal year.

“(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.”

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall apply to fiscal years ending after the date of the enactment of this Act.

SEC. 5 INTERIM FINAL REGULATIONS.

(a) *IN GENERAL.*—Subject to subsection (b), the Secretary of Health and Human Services shall issue such regulations (on an interim final or other basis) as may be necessary to implement this Act and the amendments made by this Act.

(b) *REGULATIONS CHANGING TREATMENT OF INTERGOVERNMENTAL TRANSFERS.*—The Secretary may not issue an interim final regulation that changes the treatment (specified in section 433.45(a) of title 42, Code of Federal Regulations) of public funds as a source of State share of financial participation under title XIX of the Social Security Act, except as may be necessary to permit the Secretary to deny Federal financial participation for public funds described in section 1903(w)(6)(A) of such Act (as added by section 2(a) of this Act) that are derived from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of such Act.

(c) *CONSULTATION WITH STATES.*—The Secretary shall consult with the States before issuing any regulations under this Act.

And the Senate agree to the same.

JOHN D. DINGELL,
HENRY A. WAXMAN,
NORMAN F. LENT,
Managers on the Part of the House.

LLOYD BENTSEN,
JAY ROCKEFELLER,
DONALD W. RIEGLE,
BOB PACKWOOD,
DAVE DURENBERGER,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3595), to delay until September 30, 1992, the issuance of any regulations by the Secretary of Health and Human Services changing the treatment of voluntary contributions and provider-specific taxes by States as a source of a State's expenditures for which Federal financial participation is available under the medicaid program and to maintain the treatment of intergovernmental transfers as such a source, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. USE OF VOLUNTARY CONTRIBUTIONS, PROVIDER-SPECIFIC TAXES, AND INTERGOVERNMENTAL TRANSFERS BY STATES TO RECEIVE FEDERAL MATCHING FUNDS UNDER MEDICAID

Current Law

The Technical and Miscellaneous Revenue Act of 1988, as amended by the Omnibus Budget Reconciliation Act of 1990, prohibits the Secretary from issuing any final regulation prior to December 31, 1991, changing the treatment of voluntary contributions or provider-paid taxes used by States to receive Federal matching funds. The Omnibus Budget Reconciliation Act of 1990 prohibits the Secretary from denying or limiting payments to a State from expenditures attributable to taxes, whether or not of general applicability, imposed with respect to the provision of medical services. The Secretary is permitted to deny matching funds for Medicaid payments made to reimburse a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF-MR) for taxes imposed by a State solely with respect to such facilities.

House Bill

Extends the moratorium on issuance of new regulations through September 30, 1992. Permanently prohibits the issuance of regula-

tions that change the treatment of public funds used as the State share of Medicaid, including public funds contributed by an agency that provides Medicaid services. Provides that any regulation changing the treatment of voluntary contributions may not apply to contributions made before January 1, 1993, except that FY 1993 Federal financial participation (FFP) related to a State's use of contributions must not exceed the amount of FFP related to such contributions in FY 1991. Prohibits the Secretary from reducing payments to States based on quarterly State expenditure estimates because such estimates include amounts attributable to contributions, intergovernmental transfers, or provider-paid taxes, or from assessing any penalty or taking other regulatory action against a State related to its use of such contributions, transfers, or taxes. The prohibitions apply to payments for quarters beginning on or after January 1, 1992, and ending on or before September 30, 1992 (for intergovernmental transfers and provider-paid taxes) or December 31, 1992 (for voluntary contributions), and to actions taken by the Secretary during the same periods.

Senate Amendment

Provides that, for the purpose of computing Federal matching funds, State Medicaid spending for a quarter (other than in Arizona) is to be reduced by the amount of any revenues received by the State or a local government on or after January 1, 1992, from:

Provider-related donations (donations from a medical provider, related entity, or administrative contractor), except "bonafide" donations, and donations in the form of payment for outstanding Medicaid eligibility workers. Beginning in Federal FY 1993, donations related to outstationing are limited to 10 percent of State administrative costs.

Health care related taxes (those related to provision of health services and 85% paid by providers or those not equally imposed on non-health items) that are not broad-based. Broad-based taxes are defined as those uniformly imposed on all non-Federal nonpublic providers in the same class in the State or locality or all items or services in the class furnished by such providers. A tax is imposed uniformly if the amount, rate, and or base for the tax is the same for all subject providers, and the tax does not provide for credits, deductions or exclusions that have the effect of refunding all or a portion of the tax. A tax may be uniform even if it applies only to services not covered under Medicaid or Medicare or non-Medicare revenues. The Secretary may treat a tax as broad-based on application by the State if the tax and related spending are generally redistributive and the tax and Medicaid payments are not directly correlated. Waivers may include exemptions for rural or sole community providers.

Health care related taxes that are broad-based but to which a hold harmless provision applies. A hold harmless provision is one that provides for: a non-Medicaid payment to the provider that is correlated to the tax or to differences between the tax and Medicaid payments; Medicaid payment varying on the

basis of taxes paid; or the State or locality guarantees that some or all of the tax will be offset in some other way.

Broad-based taxes in amounts that exceed 25 percent of the State share of Medicaid or (if greater) the State's "base percentage" in all or part of State fiscal years beginning on or after January 1, 1992, and before October 1, 1995. The base percentage is equal to the total of provider donations and/or health care related taxes (whether or not permissible) projected to be collected during the State 1992 fiscal year, divided by the estimated State share of Medicaid spending for the year. In the case of a tax not in effect (or increased) during the full base year, the Secretary is to compute the base percentage as if it were in effect for the full year. Donations are to be counted only under a program in effect or reported to the Secretary by September 30, 1991; taxes are to be counted if they were in effect or legislation or regulations had been adopted, as of November 22, 1991.

Permits matching for certain otherwise prohibited revenues received before October 1, 1992 (for States with fiscal years beginning on or before July 1), January 1, 1993 (for States with fiscal years beginning after July 1), or July 1, 1993 (for a State that has an enacted provider tax on November 4, 1991, or whose legislature is not scheduled to meet in 1992 or 1993); prohibits a disallowance or withholding of FFP related to donations or taxes before the applicable date. Matching is permitted for donations only under a program in effect or reported to the Secretary by September 30, 1991. Countable donations for a State's 1993 fiscal year may not exceed those for the State's 1992 fiscal year. Matching is permitted for non-broad-based taxes, or broad-based taxes with a hold harmless provision, only if the taxes were in effect or legislation or regulations had been adopted, as of November 22, 1991. Increases after that date are not permitted. The sum of allowed donations and taxes (including broad-based taxes) for the part of a State's fiscal year occurring in calendar year 1992, or for all of State fiscal year 1993 may not exceed 25 percent (or the base percentage) of the State share of Medicaid.

Prohibits the Secretary from restricting States' use of funds derived from State or local taxes (including funds appropriated to State-owned teaching hospitals) transferred from or certified by local government units (including units that are providers) unless the transfers exceed the 40 percent limit on local government sharing in Medicaid or stem from otherwise prohibited donations or taxes.

Conference agreement

The agreement includes the Senate amendment with modifications. The Secretary is required to withdraw the October 31, 1991, interim final rule with respect to donations and taxes. The Secretary may not change current treatment of intergovernmental transfers except through the formal APA regulatory process (except as needed to deny matching for public funds described in section 1903(w)(6)(A) that are derived from donations or taxes that

would not otherwise be recognized). Use appropriations made to State university teaching hospitals is to be treated as a permissible transfer. The conferees note that current transfers from county or other local teaching hospitals continue to be permissible if not derived from sources of revenue prohibited under this act. The conferees intend the provision of section 1903(w)(6)(A) to prohibit the Secretary from denying Federal financial participation for expenditures resulting from State use of funds referenced in that provision.

2. RESTRICTIONS ON AGGREGATE PAYMENTS FOR DISPROPORTIONATE SHARE HOSPITALS

Current Law

Prohibits the Secretary from limiting payment adjustments made by States to hospitals serving a disproportionate number of low-income patients with special needs.

House Bill

No provision.

Senate Amendment

Effective January 1, 1992, establishes a national limit on disproportionate share hospital payment adjustments during each fiscal year equal to 12 percent of total Medicaid spending for that year. Limits a State's disproportionate share adjustments:

In the part of FY 1992 beginning on or after January 1, 1992, to those made under the State plan in effect or as submitted by September 30, 1991, or under a methodology established and in effect by that date, or legislation or regulations adopted by that date. A State plan amendment in effect or submitted by November 26, 1991, may be used if it designates only disproportionate share hospitals with a Medicaid or low-income percentage at or above the Statewide arithmetic mean. Higher payment adjustments are permitted if necessary to meet the minimum prescribed by Medicaid law.

For FY 1993 and subsequent fiscal years, to the amount of the State's disproportionate share hospital (DSH) allotment. The DSH allotment for a State is equal to the previous year's allotment (or, for FY 1993, its "base allotment"), increased by the State growth factor and the State supplemental amount for the fiscal year. The base allotment is equal to the greater of the State's payment adjustment during FY 1992 (subject to the limits for that year) or \$1 million. The growth factor is the annual percentage increase in the State's Medicaid spending. The supplemental amount is an amount payable to States that are not high DSH States. (A State is a high DSH State for a fiscal year if its base allotment exceeds 12 percent of its total Medicaid spending for that fiscal year.)

The supplemental amounts are established from a pool whose size is determined by subtracting from the amount of the national DSH limit the amounts of: (a) the base allotment for high DSH States, (b) total allotments to non-high DSH

States for the previous year, (c) total "growth amounts" for non-high DSH States for the current year, and (d) any additional amounts needed to bring State's payment adjustments up to statutory minimums. A State's growth amount is the greater of: the State's allotment for the previous year times the growth factor; or the difference between the allotment for the previous year and 12 percent of total current year Medicaid spending. The supplemental amount for each non-high DSH State is the lesser of (a) a share of the pool proportionate to the State's share of all Medicaid spending by non-high DSH States or (b) the amount that would raise the State's allowable payment adjustments to 12 percent of its Medicaid spending.

Requires the Secretary to publish State allotments and national limits for each fiscal year before the beginning of the year. Limits on payment adjustments do not apply in Arizona.

Prohibits a State from using DSH payment adjustments to hold providers harmless for health care related taxes after the effective date of limits on the use of such taxes. With this exception, prohibits the Secretary from restricting a State's authority to designate disproportionate share hospitals.

Conference Agreement

The agreement includes the Senate amendment, with modifications.

After January 1, 1996, a state will not be subject to the aggregate limit on payment adjustments if it designates as DSH's only facilities whose low-income or Medicaid utilization rate exceeds the State mean, that account for at least 1 percent of all Medicaid days in the State, or that meet other criteria established by the Secretary, taking into account the special circumstances of rural, sole community, and childrens hospitals.

This option will be available only after Congress has established limits in law on payment adjustments to DSH hospitals or States electing the option. The Prospective Payment Assessment Commission is required to submit a report to Congress by January 1, 1994, on appropriate methods for establishing appropriate minimum and maximum adjustment amounts and criteria for DSH designation.

3. REPORT

Current Law

No provision.

House Bill

Requires the Secretary to report to the House Energy and Commerce and Senate Finance Committees by February 3, 1992, on any regulations the Secretary intends to issue to limit the use of contributions and provider-specific taxes, the specific types of contributions and taxes that would remain permissible, and any legislation the Secretary thinks appropriate.

Senate Amendment

No provision.

Conference Agreement

The agreement does not include the House provision.

4. BUDGET COMPLIANCE PROVISIONS

Current Law

No provision.

House Bill

Provides that the applicable cost estimates for the purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 shall 0 in increased outlays and receipts for FY 1991 through FY 1995.

Senate Amendment

No provision.

Conference Agreement

The agreement does not include the House provision.

5. STATE REPORTS

Current Law

No provision.

House Bill

No provision.

Senate Amendment

Requires States to report annually on donations received and taxes collected by the State or local governments during each fiscal year and the amount of payment adjustments made to disproportionate share providers during the year, beginning with fiscal years ending after the date of enactment.

Conference Agreement

The agreement includes the Senate amendment.

6. INTERIM FINAL REGULATIONS

Current Law

No provision.

House Bill

No provision.

Amendment

Requires the Secretary, after consultation with States, to issue implementing regulations.

JOHN D. DINGELL,
HENRY A. WAXMAN,
NORMAN F. LENT,

Managers on the Part of the House.

LLOYD BENTSEN,
JAY ROCKEFELLER,
DONALD W. RIEGLE,
BOB PACKWOOD,
DAVE DURENBERGER.

Managers on the Part of the Senate.



Finder's Aid
P.L. 102-318 (106 Stat. 290) Approved July 3, 1992
Unemployment Compensation Amendments of 1992

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>106 Stat.</u>	<u>H.Rep 102-543 Pt. 1</u>	<u>H.Rep 102-543 Pt. 2</u>	<u>H.Conf. Rep. 102-650</u>
Grants to States for Unemployment Compensation Administration - Payments	302(c) New	301(a)	297	30, 59	3, 8	9, 39
Grants to States for Unemployment Compensation Administration - Provisions of State Laws	303(a)(5)	401(a)(3)	298	32, 59- 60	4, 8	10, 40-
Employment Security Administration Account	901(f)(2)	531(d)(1) (A)	316	35-36, 61	8	29, 48- 49
Employment Security Administration Account	901(f)(2) (B) Stricken	531(d)(1) (B)	317	35-36, 61	8	29, 48- 49
Employment Security Administration Account	901(g) Stricken	531(d)(2)	317	35-36	8	29, 48- 49
Transfers to Medical Unemployment Account	902(a)(2)	531(b)	316	35-36, 62	8	28, 48- 49
Unemployment Trust Fund	904(g)	531(d)(3)	317	35-36, 62-63	8	29, 48- 49
Extended Unemployment Compensation Account	905(b)(1)	531(a)(1)	315	35-36, 63	8	27-28, 48
Extended Unemployment Compensation Account	905(b)(2) (B)	531(a)(2)	316	35-36, 64	8	27-28, 48
Borrowing between Federal Accounts	910 New	531(c)	316	35-36, 64	8	28-29

Public Law 102-318
102d Congress

An Act

July 3, 1992
[H.R. 5260]

To extend the emergency unemployment compensation program, to revise the trigger provisions contained in the extended unemployment compensation program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Unemployment Compensation Amendments of 1992”.

**TITLE I—EXTENSION OF EMERGENCY
UNEMPLOYMENT COMPENSATION
PROGRAM**

SEC. 101. EXTENSION OF PROGRAM.

(a) **GENERAL RULE.**—Sections 102(f)(1) and 106(a)(2) of the Emergency Unemployment Compensation Act of 1991 (Public Law 102-164, as amended) are each amended by striking “July 4, 1992” and inserting “March 6, 1993”.

(b) **WEEKS OF BENEFITS AVAILABLE DURING EXTENSION.**—Subparagraph (A) of section 102(b)(2) of such Act is amended by striking clause (ii) and the flush paragraph at the end thereof and inserting the following:

“(ii) **REDUCTION FOR WEEKS AFTER JUNE 13, 1992.**—
In the case of weeks beginning after June 13, 1992—

“(I) clause (i) of this subparagraph shall be applied by substituting ‘26’ for ‘33’, and by substituting ‘20’ for ‘26’, and

“(II) subparagraph (A) of paragraph (1) shall be applied by substituting ‘100 percent’ for ‘130 percent’.

“(iii) **REDUCTION FOR WEEKS IN 7-PERCENT PERIOD.**—
In the case of weeks beginning in a 7-percent period—

“(I) clause (ii) of this subparagraph shall not apply,

“(II) clause (i) of this subparagraph shall be applied by substituting ‘15’ for ‘33’, and by substituting ‘10’ for ‘26’, and

“(III) subparagraph (A) of paragraph (1) shall be applied by substituting ‘60 percent’ for ‘130 percent’.

“(iv) **REDUCTION FOR WEEKS IN 6.8-PERCENT PERIOD.**—
In the case of weeks beginning in a 6.8-percent period—

“(I) clauses (ii) and (iii) of this subparagraph shall not apply,

Unemployment
Compensation
Amendments of
1992.
Inter-
governmental
relations.
26 USC 1 note.

26 USC 3304
note.

“(7) Paragraphs (3) and (4) shall not apply to weeks of unemployment beginning after March 6, 1993, and before January 1, 1995, and no provision of State law in conformity with such paragraphs shall apply during such period.”

Effective date.

(2) **STUDY.**—The Federal Advisory Council established under section 908 of the Social Security Act shall conduct a study of the provisions suspended by the amendment made by paragraph (1). Not later than February 1, 1994, such Council shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate, a report of its recommendations on such suspended provisions (including whether such provisions should be repealed or revised).

26 USC 3304 note.

Reports.

TITLE III—MODIFICATIONS TO FEDERAL UNEMPLOYMENT TAX

SEC. 301. INFORMATION REQUIRED WITH RESPECT TO TAXATION OF UNEMPLOYMENT BENEFITS.

26 USC 3304 note.

(a) INFORMATION ON UNEMPLOYMENT BENEFITS.—

(1) **GENERAL RULE.**—The State agency in each State shall provide to an individual filing a claim for compensation under the State unemployment compensation law a written explanation of the Federal and State income taxation of unemployment benefits and of the requirements to make payments of estimated Federal and State income taxes.

(2) **STATE AGENCY.**—For purposes of this subsection, the term “State agency” has the meaning given such term by section 3306(e) of the Internal Revenue Code of 1986.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on October 1, 1992.

SEC. 302. MAILING OF CERTAIN INFORMATION PERMITTED.

(a) **GENERAL RULE.**—Section 302 of the Social Security Act (42 U.S.C. 502) is amended by adding at the end thereof the following new subsection:

“(c) No portion of the cost of mailing a statement under section 6050B(b) of the Internal Revenue Code of 1986 (relating to unemployment compensation) shall be treated as not being a cost for the proper and efficient administration of the State unemployment compensation law by reason of including with such statement information about the earned income credit provided by section 32 of the Internal Revenue Code of 1986. The preceding sentence shall not apply if the inclusion of such information increases the postage required to mail such statement.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

42 USC 502 note.

SEC. 303. EXTENSION OF EXISTING TREATMENT OF CERTAIN AGRICULTURAL WORKERS.

(a) **GENERAL RULE.**—Subparagraph (B) of section 3306(c)(1) of the Internal Revenue Code of 1986 is amended by striking “January 1, 1993” and inserting “January 1, 1995”.

26 USC 3306.

(b) **REPORT.**—Not later than February 1, 1994, the Advisory Council on Unemployment Compensation shall submit a report to the Committee on Ways and Means of the House of Representatives

42 USC 1108 note.

and the Committee on Finance of the Senate on its recommendations with respect to the treatment of agricultural labor performed by aliens.

26 USC 3302
note.

SEC. 304. EXTENSION OF PERIOD FOR REPAYMENT OF FEDERAL LOANS TO STATE UNEMPLOYMENT FUNDS.

(a) **GENERAL RULE.**—If the Secretary of Labor determines that a State meets the requirements of subsection (b), paragraph (2) of section 3302(c) of the Internal Revenue Code of 1986 shall be applied with respect to such State for taxable years after 1991—

(1) by substituting “third” for “second” in subparagraph (A)(i),

(2) by substituting “fourth or fifth” for “third or fourth” in subparagraph (B), and

(3) by substituting “sixth” for “fifth” in subparagraph (C).

(b) **REQUIREMENTS.**—A State meets the requirements of this subsection if, during calendar year 1992 or 1993, the State amended its unemployment compensation law to increase estimated contributions required under such law by at least 25 percent.

(c) **SPECIAL RULE.**—This section shall not apply to any taxable year after 1994 unless—

(1) such taxable year is in a series of consecutive taxable years as of the beginning of each of which there was a balance referred to in section 3302(c)(2) of such Code, and

(2) such series includes a taxable year beginning in 1992, 1993, or 1994.

TITLE IV—MODIFICATION TO REGULAR STATE UNEMPLOYMENT COMPENSATION PROGRAMS

SEC. 401. TREATMENT OF SHORT-TIME UNEMPLOYMENT COMPENSATION PROGRAMS.

(a) **AUTHORIZATION OF PROGRAMS.**—

26 USC 3304.

(1) Paragraph (4) of section 3304(a) of the Internal Revenue Code of 1986 is amended by striking “and” at the end of subparagraph (C), by inserting “and” at the end of subparagraph (D) and by adding at the end thereof the following new subparagraph:

“(E) amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor;”

26 USC 3306.

(2) Subsection (f) of section 3306 of such Code is amended by striking “and” at the end of paragraph (2) by striking the period at the end of paragraph (3) and inserting “; and”, and by adding at the end thereof the following new paragraph:

“(4) amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor.”

42 USC 503.

(3) Section 303(a)(5) of the Social Security Act is amended by inserting before “; and” the following “: *Provided further*, That amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor”.

(c) EXCLUSION FROM INCOME.—

(1) **QUALIFIED TRUSTS.**—Subsection (e) of section 402 (relating to taxability of beneficiary of employees' trust), as amended by section 521, is amended by adding at the end the following new paragraph: 26 USC 402.

“(6) **DIRECT TRUSTEE-TO-TRUSTEE TRANSFERS.**—Any amount transferred in a direct trustee-to-trustee transfer in accordance with section 401(a)(31) shall not be includible in gross income for the taxable year of such transfer.”

(2) **EMPLOYEE ANNUITIES.**—Subsection (a) of section 403 is amended by adding at the end the following new paragraph: 26 USC 403.

“(5) **DIRECT TRUSTEE-TO-TRUSTEE TRANSFER.**—Any amount transferred in a direct trustee-to-trustee transfer in accordance with section 401(a)(31) shall not be includible in gross income for the taxable year of such transfer.”

(3) **ANNUITY CONTRACTS PURCHASED BY CHARITIES AND PUBLIC SCHOOLS.**—Section 403(b)(10) is amended by adding at the end the following new sentence: “Any amount transferred in an direct trustee-to-trustee transfer in accordance with section 401(a)(31) shall not be includible in gross income for the taxable year of the transfer.”

(d) EFFECTIVE DATES.—

26 USC 401 note.

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall apply to distributions after December 31, 1992.

(2) **TRANSITION RULE FOR CERTAIN ANNUITY CONTRACTS.**—If, as of July 1, 1992, a State law prohibits a direct trustee-to-trustee transfer from an annuity contract described in section 403(b) of the Internal Revenue Code of 1986 which was purchased for an employee by an employer which is a State or a political subdivision thereof (or an agency or instrumentality of any 1 or more of either), the amendments made by this section shall not apply to distributions before the earlier of—

(A) 90 days after the first day after July 1, 1992, on which such transfer is allowed under State law, or

(B) January 1, 1994.

SEC. 523. DATE FOR ADOPTION OF PLAN AMENDMENTS.

26 USC 401 note.

If any amendment made by this subtitle requires an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after January 1, 1994, if—

(1) during the period after such amendment takes effect and before such first plan year, the plan is operated in accordance with the requirements of such amendment, and

(2) such plan amendment applies retroactively to such period.

Subtitle C—Other Provisions

SEC. 531. MODIFICATIONS TO FEDERAL UNEMPLOYMENT ACCOUNTS.**(a) MODIFICATIONS TO EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT.—**

(1) **TRANSFERS TO ACCOUNT.**—Paragraph (1) of section 905(b) of the Social Security Act is amended to read as follows—

42 USC 1105.

“(b)(1) Except as provided in paragraph (3), the Secretary of the Treasury shall transfer (as of the close of each month), from

the employment security administration account to the extended unemployment compensation account established by subsection (a), an amount determined by him to be equal to the sum of—

“(A) 100 percent of the transfers to the employment security administration account pursuant to section 901(b)(2) during such month on account of liabilities referred to in section 901(b)(1)(B), plus

“(B) 20 percent of the excess of the transfers to such account pursuant to section 901(b)(2) during such month on account of amounts referred to in section 901(b)(1)(A) over the payments during such month from the employment security administration account pursuant to section 901 (b)(3) and (d).

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (B), proper adjustments shall be made in the amounts subsequently transferred.”

42 USC 1105. (2) INCREASE IN CEILING.—Subparagraph (B) of section 905(b)(2) of such Act is amended by striking “three-eighths of 1 percent” and inserting “0.5 percent”.

42 USC 1102. (b) REDUCTION OF CEILING ON FEDERAL UNEMPLOYMENT ACCOUNT.—Paragraph (2) of section 902(a) of such Act is amended by striking “five-eighths of 1 percent” and inserting “0.25 percent”.

(c) BORROWING BETWEEN FEDERAL ACCOUNTS.—Title IX of such Act is amended by adding at the end the following new section:

“BORROWING BETWEEN FEDERAL ACCOUNTS

42 USC 1110. “SEC. 910. (a) IN GENERAL.—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that—

“(1) the amount in the employment security administration account, Federal unemployment account, or extended unemployment compensation account, is insufficient to meet the anticipated payments from the account,

“(2) such insufficiency may cause such account to borrow from the general fund of the Treasury, and

“(3) the amount in any other such account exceeds the amount necessary to meet the anticipated payments from such other account,

the Secretary shall transfer to the account referred to in paragraph (1) from the account referred to paragraph (3) an amount equal to the insufficiency determined under paragraph (1) (or, if less, the excess determined under paragraph (3)).

“(b) TREATMENT OF ADVANCE.—Any amount transferred under subsection (a)—

“(1) shall be treated as a noninterest-bearing repayable advance, and

“(2) shall not be considered in computing the amount in any account for purposes of the application of sections 901(f)(2), 902(b), and 905(b).

“(c) REPAYMENT.—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount in the account to which an advance is made under subsection (a) exceeds the amount necessary to meet the anticipated payments from the account, the Secretary shall transfer from the account to the account from which the advance was made an amount equal to the lesser of the amount so advanced or such excess.”

(d) REPEAL OF EXPIRED PROVISIONS.—

- (1) Paragraph (2) of section 901(f) of such Act is amended— 42 USC 1101.
 (A) by striking “(A) Except as provided in subparagraph
 (B), the” and inserting “The”, and
 (B) by striking subparagraph (B).

(2) Section 901 of such Act is amended by striking subsection (g).

(3) Subsection (g) of section 904 is amended by striking 42 USC 1104.
 all of such subsection that follows the 1st sentence.

(e) EFFECTIVE DATES.—

42 USC 1102
 note.

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) **CHANGES IN CEILING AMOUNTS.**—The amendments made by subsection (a)(2) and (b) shall apply to fiscal years beginning after September 30, 1993.

SEC. 532. REQUIREMENT OF DEPOSITS BY FEDERAL AGENCIES FOR UNEMPLOYMENT BENEFITS.

(a) **GENERAL RULE.**—Subsection (c) of section 8509 of title 5, United States Code, is amended by adding at the end thereof the following new paragraph:

“(3) If any Federal agency does not deposit in the Federal Employees Compensation Account any amount before the date 30 days after the date on which the Secretary of Labor has notified such agency that it is required to so deposit such amount, the Secretary of Labor shall notify the Secretary of the Treasury of the failure to make such deposit and the Secretary of the Treasury shall transfer such amount to the Federal Employees Compensation Account from amounts otherwise appropriated to such Federal agency.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to failures outstanding on the date of the enactment of this Act or at any time thereafter. 5 USC 8509 note.

SEC. 533. REPORT ON ALLOCATION OF ADMINISTRATIVE FUNDS.

Subsection (a) of section 304 of the Emergency Unemployment Compensation Act of 1991 (Public Law 102-164, as amended) is amended by striking “within the 12-month period beginning on the date of the enactment of this Act” and inserting “before December 31, 1994”. 42 USC 502 note.

SEC. 534. EXTENSION OF COMMISSION ON INTERSTATE CHILD SUPPORT.

(a) **IN GENERAL.**—Section 126 of the Family Support Act of 1988 (42 U.S.C. 666 note; 102 Stat. 2355) is amended—

(1) in subsection (d)(2), by striking “May” and inserting “August”; and

(2) in subsection (f)(1), by striking “July 1” and inserting “September 30”.

42 USC 666 note.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on June 30, 1992.

Approved July 3, 1992.

LEGISLATIVE HISTORY—H.R. 5260:

HOUSE REPORTS: Nos. 102-543, Pt. 1 (Comm. on Ways and Means) and Pt. 2 (Comm. on Government Operations), and 102-650 (Comm. of Conference).
CONGRESSIONAL RECORD, Vol. 138 (1992):

June 9, considered and passed House.

June 18, 19, considered and passed Senate, amended.

July 2, House and Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 28 (1992):
July 3, Presidential statement.

UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1992

JUNE 2, 1992.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany H.R. 5260 which on May 26, 1992, was referred jointly to the Committee on Ways and Means and the Committee on Government Operations]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5260) to extend the emergency unemployment compensation program, to revise the trigger provisions contained in the extended unemployment compensation program, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. INTRODUCTION

A. PURPOSE AND SCOPE OF THE BILL

The Committee on Ways and Means completed action on H.R. 5260 on May 27, 1992. The primary purposes of the bill are to extend the Emergency Unemployment Compensation program effectively through the end of the year and phase it out over a three-month period for new claimants and another three-month period after March 1992 for continuing claimants, reform the permanent Federal-State Extended Benefits program, and provide financing sufficient to cover the costs of the bill over the five-year projection period.

2. INFORMATION REQUIRED WITH RESPECT TO TAXATION OF UNEMPLOYMENT BENEFITS

Present law

Under the Tax Reform Act of 1986, all unemployment compensation is subject to Federal personal income taxation.

Explanation of provision

The provision requires States to provide information on the taxation of unemployment compensation and the deposit of estimated individual income taxes.

Effective date

January 1, 1993.

3. MAILING OF CERTAIN INFORMATION PERMITTED

Present law

Office of Management and Budget (OMB) Circular A-87 requires States to share in the cost of postage if they add material to such mailings even if the mailings do not add to the total cost of the postage.

Explanation of provision

The provision would allow States to include information on the Earned Income Credit (EIC) in their Form 1099-G mail at no cost as long as the additional information does not increase the postage cost of the mailing.

Effective date

October 1, 1992.

4. EXTENSION OF EXISTING TREATMENT OF CERTAIN AGRICULTURAL WORKERS

Present law

Agricultural labor performed before January 1, 1993 by an individual who is an alien admitted to the United States to perform agricultural labor under sections 214(c) and 101(a)(15)(H) of the Immigration and Nationality Act is excluded from coverage under the Federal Unemployment Tax Act.

Explanation of provision

The provision would extend current law for two years until January 1, 1995 and require the Federal Advisory Council on Unemployment Compensation to study the impact of the provision and report to Congress by February 1, 1994.

Effective date

Date of enactment.

Title IV—Modification to Regular State Unemployment Compensation Programs

1. TREATMENT OF SHORT-TIME UNEMPLOYMENT COMPENSATION PROGRAMS

Present law

All funds withdrawn from the unemployment trust fund of a State must be used solely in payment of unemployment compensation, exclusive of administrative expenses and refunds of erroneously paid sums except: (1) certain authorized disability payments; (2) certain "Reed Act" expenses; (3) authorized health insurance costs; and (4) repayments of overpayments. Short-time compensation is not mentioned explicitly.

Explanation of provision

The provision clarifies present law to ensure that fourteen States can continue to pay short-time compensation. The provision also requires the Secretary of Labor to develop model State legislation, to update it periodically, to provide technical assistance to the States, and to report to Congress on implementation of short-time compensation.

Effective date

Date of enactment.

2. BENEFIT INFORMATION REQUIREMENTS

Present law

No provision.

Explanation of provision

The provision requires States to conduct ongoing outreach programs for job losers. It would require employers to give laid off workers information on unemployment insurance eligibility and benefits.

Effective date

November 1, 1993. In the case of any State legislature which has not been in session for at least 30 days between the date of enactment and November 1, 1993, the provision will not be a requirement of the State law before 30 days after the first day on which the State's legislature is in session on or after November 1, 1993.

Title V—Financing Provisions

1. EXTENSION OF PHASEOUT OF PERSONAL EXEMPTIONS

Present law

Present law permits a personal exemption deduction from gross income for an individual, the individual's spouse, and each dependent. For 1992, the amount of this deduction is \$2,300 for each exemption claimed. This exemption amount is adjusted for inflation. The deduction for personal exemptions is phased out for taxpayers with adjusted gross income (AGI) above a threshold amount (in-

this provision are deposited, along with almost all individual income tax receipts, in the General Fund of the Treasury.

A portion of social security and tier I railroad retirement benefits is includible in gross income. An individual is required to include in gross income the lesser of: (1) 50 percent of the individual's social security or tier I railroad retirement benefits; or (2) 50 percent of the individual's modified adjusted gross income above a specified threshold. Modified adjusted gross income is defined as the sum of 50 percent of the individual's social security or tier I railroad retirement benefits plus otherwise calculated adjusted gross income plus certain tax-exempt interest. The threshold amounts are \$32,000 for married taxpayers filing joint returns and \$25,000 for unmarried taxpayers.

The Secretary of the Treasury is required to estimate the individual income tax liabilities attributable to the payment of social security and tier I railroad retirement benefits. These proceeds are transferred (credited) quarterly to the Old-Age and Survivors Insurance Trust Fund, the Disability Insurance Trust Fund, or the Railroad Retirement Trust Fund, as appropriate.

Explanation of provision

The bill requires the Secretary of the Treasury to estimate the individual income tax liabilities attributable to the receipt of unemployment compensation benefits and transfer the proceeds into the Extended Unemployment Compensation Account of the Unemployment Trust Fund.

Effective date

The provision is effective for all unemployment compensation benefits paid after December 31, 1990.

4. MODIFICATIONS TO FEDERAL UNEMPLOYMENT ACCOUNTS

Present law

Ninety percent of Federal unemployment tax revenue flows into the Employment Security Administration Account (ESAA), which funds the administration of the unemployment insurance and employment services. Ten percent flows into the Extended Unemployment Compensation Account (EUCA), which funds the Extended Benefits (EB) and Emergency Unemployment Compensation (EUC) programs. Each account has a ceiling. The excess over the ceilings flows into the Federal Unemployment Account, which provides loans to insolvent State programs. If all three accounts overflow, the excess flows to the State accounts in proportion to their share of total wages paid Nationwide.

Explanation of provision

The provision changes the flow of Federal unemployment tax revenue into the three Federal accounts such that the administration account receives 80 percent and the Extended Unemployment Compensation Account (EUCA) receives 20 percent of the annual revenue. Also, it: authorizes interest-free borrowing between accounts; lowers the ceiling in the loan account from 0.625 percent to 0.125 percent of total annual wages; raises the ceiling on the Ex-

tended Unemployment Compensation Account (EUCA) from 0.375 percent to 0.625 percent of total annual wages; makes the ceiling changes effective in fiscal year 1994; and retains the current law provision that when all three accounts are full, the excess revenue flows back to the States in proportion to their share of total wages Nationwide.

Effective date

Changes in ceiling amounts are effective October 1, 1993. All other provisions are effective on date of enactment.

5. REQUIREMENT OF DEPOSITS BY FEDERAL AGENCIES FOR
UNEMPLOYMENT BENEFITS

Present law

No provision.

Explanation of provision

The provision authorizes the Secretary of Treasury to transfer amounts owed to the Federal Employees Compensation Account from amounts otherwise appropriated to such Federal agency if 30 days have past since the date on which the Secretary of Labor notified the agency that it was required to deposit such amount.

Effective date

Provision applies to failures to make such deposits outstanding on the date of enactment or at any time thereafter.

6. REPORT ON ALLOCATION OF ADMINISTRATIVE FUNDS

Present law

The Emergency Unemployment Compensation Act of 1991 authorized a study of the basic method of allocating funds among States for administration of unemployment insurance. The report is due no later than November 17, 1992.

Explanation of provision

The provision changes the due date of the report to December 31, 1994.

Effective date

Date of enactment.

Title VII—Budgetary Treatment

1. TREATMENT UNDER PAY-AS-YOU-GO PROCEDURES

Present law

New entitlement spending for benefits from the unemployment trust fund is subject to the pay-as-you-go requirements of the Balanced Budget and Deficit Control Act of 1985, as amended. Spending for administration is treated as discretionary spending, and is subject to the domestic discretionary spending caps in the Budget Act.

Subtitle F—Procedure and Administration

CHAPTER 62—TIME AND PLACE FOR PAYING TAX

Subchapter A—Place and Due Date for Payment of Tax

SEC. 6157. PAYMENT OF FEDERAL UNEMPLOYMENT TAX ON QUARTERLY OR OTHER TIME PERIOD BASIS.

(a) * * *

[(b) COMPUTATION OF TAX.—The tax for any calendar quarter or other period referred to in paragraph (1) or (2) of subsection (a) shall be computed by multiplying the amount of wages (as defined in section 3306(b)) paid in such calendar quarter or other period by 0.5 percent [0.6 percent for 1985 and thereafter]. In the case of wages paid in any calendar quarter or other period during a calendar year to which paragraph (1) of section 3301 applies, the amount of such wages shall be multiplied by 0.8 percent in lieu of 0.6 percent.]

(b) COMPUTATION OF TAX.—The tax for any calendar quarter or other period referred to in paragraph (1) or (2) of subsection (a) shall be determined without regard to paragraph (1) of section 3301(a).

* * * * *

SOCIAL SECURITY ACT

* * * * *

TITLE III—GRANTS TO STATES FOR UNEMPLOYMENT COMPENSATION ADMINISTRATION

* * * * *

PAYMENTS TO STATES

SEC. 302. (a) * * *

* * * * *

(c) No portion of the cost of mailing statements under section 6050B(b) of the Internal Revenue Code of 1986 (relating to unemployment compensation) shall be treated as not being a cost for the proper and efficient administration of the State unemployment compensation law by reason of including with such statement information about the earned income credit provided by section 32 of the Internal Revenue Code of 1986. The preceding sentence shall not apply if the inclusion of such information increases the postage required to mail such statement.

* * * * *

PROVISIONS OF STATE LAWS

SEC. 303. (a) The Secretary of Labor shall make no certification for payment to any State unless he finds that the law of such State, approved by the Secretary of Labor under the Federal Unemployment Tax Act, includes provision for—

(1) * * *

* * * * *

(5) Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b) of the Federal Unemployment Tax Act: *Provided*, That an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration: *Provided further*, That the amounts specified by section 903(c)(2) may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices: *Provided further*, That nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor: *Provided further*, That amounts may be deducted from unemployment benefits and used to repay overpayments as provided in subsection (g): *Provided further*, That amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor; and

* * * * *

TITLE IX—MISCELLANEOUS PROVISIONS RELATING TO EMPLOYMENT SECURITY

EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT

Establishment of Account

SEC. 901. (a) * * *

Appropriations to Account

(b)(1) There is hereby appropriated to the Unemployment Trust Fund for credit to the employment security administration account, out of any moneys in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1961, and for each fiscal year thereafter, [an amount equal to 100 per centum of the tax (including interest, penalties, and additions to the tax) received during the fiscal year under the Federal Unemployment Tax Act and covered into the Treasury.] *an amount equal to—*

(A) 100 percent of the tax (including interest, penalties, and additions to the tax) received during the fiscal year under the Federal Unemployment Tax Act (26 U.S.C. 3301 et seq.) and covered into the Treasury, plus

(B) the aggregate increase in tax liabilities under chapter 1 of the Internal Revenue Code of 1986 which is attributable to the

application of section 85 of such Code (relating to taxation of unemployment compensation).

(2) The amount appropriated by paragraph (1) shall be transferred at least monthly from the general fund of the Treasury to the Unemployment Trust Fund and credited to the employment security administration account. Each such transfer shall be based on estimates made by the Secretary of the Treasury of the amounts received in the Treasury (or, in the case of amounts referred to in paragraph (1)(B), of the amount of unemployment compensation paid during the month). Proper adjustments shall be made in the amounts subsequently transferred, to the extent prior estimates (including estimates for the fiscal year ending June 30, 1960) were in excess of or were less than the amounts required to be transferred.

* * * * *

Determination of Excess and Amount To Be Retained in Employment Security Administration Account

(f)(1) * * *

(2) [(A) Except as provided in subparagraph (B), the] *The excess in the employment security administration account as of the close of any fiscal year is the amount by which the net balance in such account as of such time (after the application of section 902(b) and section 901(f)(3)(C) exceeds the net balance in the employment security administration account as of the beginning of that fiscal year (including the fiscal year for which the excess is being computed) for which the net balance was higher than as of the beginning of any other such fiscal year.*

[(B) With respect to the fiscal years ending June 30, 1970, June 30, 1971, and June 30, 1972, the balance in the employment security administration account at the close of each such fiscal year shall not be considered excess but shall be retained in the account for use as provided in paragraph (1) of subsection (c).]

* * * * *

[Transfers For Calendar Years 1988, 1989, and 1990

[(g)(1) With respect to calendar years 1988, 1989, and 1990, the Secretary of the Treasury shall transfer from the employment security administration account—

[(A) to the Federal unemployment account an amount equal to 50 percent of the amount to tax received under section 3301(1) of the Federal Unemployment Tax Act which is attributable to the difference in the tax rates between paragraphs (1) and (2) of such section; and

[(B) to the extended unemployment compensation account an amount equal to 50 percent of such amount of tax received.

[(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2) with respect to wages paid during such calendar years.]

TRANSFERS TO FEDERAL UNEMPLOYMENT ACCOUNT AND REPORT TO CONGRESS

TRANSFERS TO FEDERAL UNEMPLOYMENT ACCOUNT

SEC. 902. (a) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year and the entire amount of such excess is not retained in the employment security administration account or transferred to the extended unemployment compensation account as provided in section 901(f)(3), there shall be transferred (as of the beginning of the succeeding fiscal year) to the Federal unemployment account the balance of such excess or so much thereof as is required to increase the amount in the Federal unemployment account to whichever of the following is the greater:

- (1) \$550 million, or
- (2) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to five-eighths of 1 percent *0.125 percent* of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

* * * * *

UNEMPLOYMENT TRUST FUND

Establishment, etc.

SEC. 904. (a) * * *

* * * * *

Federal Unemployment Account

(g) There is hereby established in the Unemployment Trust Fund Federal unemployment account. [There is hereby authorized to be appropriated to such Federal unemployment account a sum equal to (1) the excess of taxes collected prior to July 1, 1946, under title IX of this Act or under the Federal Unemployment Tax Act, over the total unemployment administrative expenditures made prior to July 1, 1946, plus (2) the excess of taxes collected under the Federal Unemployment Tax Act after June 30, 1946, and prior to July 1, 1953, over the unemployment administrative expenditures made after June 30, 1946 and prior to July 1, 1953. As used in this subsection, the term "unemployment administrative expenditures" means expenditures for grants under title III of this Act, expenditures for the administration of that title by the Social Security Board, the Federal Security Administrator, or the Secretary of Labor, and expenditures for the administration of title IX of this Act, or of the Federal Unemployment Tax Act, by the Department of the Treasury, the Social Security Board, the Federal Security Administrator, or the Secretary of Labor. For the purposes of this subsection, there shall be deducted from the total amount of taxes collected prior to July 1, 1943, under title IX of this Act, the sum of

\$40,561,886.43 which was authorized to be appropriated by the Act of August 24, 1937 (50 Stat. 754), and the sum of \$18,451,846 which was authorized to be appropriated by section 11(b) of the Railroad Unemployment Insurance Act.】

EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT

ESTABLISHMENT OF ACCOUNT

SEC. 905. (a) * * *

TRANSFERS TO ACCOUNT

【(b)(1) Except as provided by paragraph (3), the Secretary of the Treasury shall transfer (as of the close of July 1970, and each month thereafter), from the employment security administration account to the extended unemployment compensation account established by subsection (a), an amount determined by him to be equal, in the case of any month before April 1972, to one-fifth, and in the case of any month after March 1972, to one-tenth, of the amount by which—

【(A) transfers to the employment security administration account pursuant to section 901(b)(2) during such month, exceed

【(B) payments during such month from the employment security administration account pursuant to section 901(b)(3) and (d).

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (A), proper adjustments shall be made in the amounts subsequently transferred.】

(b)(1) Except as provided in paragraph (3), the Secretary of the Treasury shall transfer (as of the close of each month), from the employment security administration account to the extended unemployment compensation account established by subsection (a), an amount determined by him to be equal to the sum of—

(A) 100 percent of the transfers to the employment security administration account pursuant to section 901(b)(2) during such month on account of liabilities referred to in section 901(b)(1)(B), plus

(B) 20 percent of the excess of the transfers to such account pursuant to section 901(b)(2) during such month on account of amounts referred to in section 901(b)(1)(A) over the payments during such month from the employment security administration account pursuant to section 901 (b)(3) and (d).

If for such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (B), proper adjustments shall be made in the amounts subsequently transferred.

(2) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year beginning after June 30, 1972, there shall be transferred (as of the beginning of the succeeding fiscal year) to the extended unemployment compensation account the total amount of such excess or so much thereof as is required to increase the amount in the extended un-

employment compensation account to whichever of the following is the greater:

(A) \$750,000,000, or

(B) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to [three-eighths of 1 percent] 0.625 percent of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

* * * * *

BORROWING BETWEEN FEDERAL ACCOUNTS

SEC. 910. (a) IN GENERAL.—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that—

(1) the amount in the employment security administration account, Federal unemployment account, or extended unemployment compensation account, is insufficient to meet the anticipated payments from the account during the next 3 months,

(2) such insufficiency may cause such account to borrow from the general fund of the Treasury, and

(3) the amount in any other such account exceeds the amount necessary to meet the anticipated payments from such other account during the next 3 months,

the Secretary shall transfer to the account referred to in paragraph (1) from the account referred to in paragraph (3) an amount equal to the insufficiency determined under paragraph (1) (or, if less, the excess determined under paragraph (3)).

(b) TREATMENT OF ADVANCE.—Any amount transferred under subsection (a)—

(1) shall be treated as a noninterest-bearing repayable advance, and

(2) shall not be considered in computing the amount in any account for purposes of the application of sections 901(f)(2), 902(c), and 905(b).

(c) REPAYMENT.—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount in the account to which an advance is made under subsection (a) exceeds the amount necessary to meet the anticipated payments from the account during the next 3 months, the Secretary shall transfer from the account to the account from which the advance was made an amount equal to the lesser of the amount so advanced or such excess.

SECTION 8509 OF TITLE 5, UNITED STATES CODE

§ 8509. Federal Employees Compensation Account

(a) * * *

* * * * *

UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1992

JUNE 9, 1992.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. CONYERS, from the Committee on Government Operations,
submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 5260 which on May 26, 1992, was referred jointly to the Committee on Ways and Means and the Committee on Government Operations]

[Including cost estimate of the Congressional Budget Office]

The Committee on Government Operations, to whom was referred the bill (H.R. 5260) to extend the emergency unemployment compensation program, to revise the trigger provisions contained in the extended unemployment compensation program, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

SUMMARY AND PURPOSE

The primary purpose of H.R. 5260 is to extend the Emergency Unemployment Compensation program through the end of the year, to reform the permanent Federal State Extended Benefits program, and to provide financing adequate to meet the costs of the bill over the next five years. The bill also provides for the phasing out of the Emergency Unemployment Compensation program over a three-month period for new claimants and another three month period after March 1993 for continuing claimants. Finally, the bill exempts emergency unemployment compensation from sequestration, and exempts new budget authority, outlays and receipts from the pay-as-you-go provisions of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

of the pay-as-you-go requirements of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. This problem is addressed by Title VI of the bill which exempts these changes from the pay-as-you-go requirements and sequestration.

Although the Committee is committed to maintaining the fiscal discipline embodied in the pay-as-you-go provisions of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, the need for counter-cyclical unemployment compensation justifies the modest departure in H.R. 5260 from strict pay-a-you-go requirements. Overall, the revenue generating provisions of H.R. 5260 fully offset its additional unemployment compensation expenditures. This overall balance, coupled with the urgent need for additional aid to the unemployed, outweigh any marginal benefit of strict adherence to pay-as-you-go principles.

Similarly, in the Committee's judgment, extended unemployment compensation benefits should be exempted for sequestration under the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. With offsetting revenues identified and placed in law by H.R. 5260, the monies needed to finance the extended unemployment compensation provided by the bill are assured. Sequestration of funding for a program with such specifically identified offsetting revenues thus serves no deficit reduction objective with respect to H.R. 5260. Particularly in view of the critical need for extended unemployment compensation, a limited exemption from sequestration for this program as provided in H.R. 5260 is a sound and responsible course.

SECTION-BY-SECTION ANALYSIS

Bill section 1

Section 1 of the Bill provides that the short title of the bill shall be the "Unemployment Compensation Amendments of 1992."

Bill title I

Title I of the bill amends the Emergency Unemployment Act of 1991 (Public Law 102-164, as amended) to provide for the extension of the Emergency Unemployment Compensation Program and provides 20 or 26 weeks of benefits to new claimants. Title I further provides for the phasing out of the Emergency Unemployment Compensation Program over a three-month period for new claimants and another three-month period after March 1993 for continuing claimants. Title I also modifies the eligibility requirements for the Emergency Unemployment Compensation Program and affects other technical modifications.

Bill title II

Title II of the bill amends the Federal-State Extended Unemployment Compensation Act of 1970 to permanently modify the provisions which trigger coverage under that program during periods of high unemployment in a State. Title II also increases the amount of federal reimbursement to 75 percent.

Bill title III

Title III amends various provisions of the Internal Revenue Code relating to Federal unemployment taxes.

Bill title IV

Title IV clarifies present law to ensure that 14 States can continue to pay short-time compensation.

Bill title V

Title V eliminates the employer tax deduction for employee compensation in excess of \$1 million, and extends for two years the "phaseout" provisions of the Internal Revenue Code which reduce personal exemptions for higher income taxpayers. These tax code changes generate the funds that offset additional budget authority and outlays resulting from the provisions of Titles I and II. Title V also provides for the transfer of income taxes on unemployment benefits to the unemployment benefits fund for 1992, and affects other technical changes in the flow of funds into federal accounts.

Bill title VI

Title VI exempts emergency unemployment compensation from sequestration and new budget authority, outlays and receipts from the pay-as-you-go provisions of the Balanced Budget and Emergency Deficit Control Act of 1985.

COMMITTEE VOTE

In compliance with clause 2(1)(2)(B) of rule XI of the rules of the House of Representatives, the following statement is made: the bill, H.R. 5260 ordered favorably reported as introduced to the House of Representatives on June 3, 1992, by a recorded vote of 27 Aye, 13 No.

OVERSIGHT FINDINGS AND RECOMMENDATIONS

In compliance with clauses 2(1)(3)(A) and 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, the oversight findings of the Committee are set forth in the section of this Report entitled DISCUSSION.

INFLATION IMPACT

In compliance with clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the provisions of H.R. 5260 are not expected to have any inflationary impact on the economy.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 3, 1992.

Hon. JOHN CONYERS, JR.,
Chairman, Committee on Government Operations,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate of H.R. 5260, the Unemployment

be \$150 million, \$65 million, \$10 million, and \$10 million in fiscal years 1994-1997, respectively.

In addition, CBO estimates there would be additional administrative costs of approximately \$60 million during the 1994-1997 period to process the additional claims for extended benefits.

Regular State Program. H.R. 5260 would require employers covered by state unemployment laws to provide workers with information about the availability of unemployment benefits. Also, states would be required to conduct outreach programs to inform job losers about the availability of unemployment benefits. Based on similar outreach programs in other entitlement programs, CBO estimates that there would be additional unemployment benefits of \$30 million annually for fiscal year 1994-1997. The bill states the provision would be effective November 1, 1993. Also, CBO estimates there would be additional administrative costs of \$1 million annually to conduct the outreach programs.

Modifications to Federal Unemployment Tax. Section 301 would modify the wage base and tax rate for the federal unemployment tax. Under current law, the Federal Unemployment Tax Act (FUTA) imposes an 0.80 percent net tax rate on the first \$7,000 paid annually by covered employers to each employee. Beginning in 1997, the net tax rate is scheduled to fall to 0.60 percent. Under H.R. 5260, in 1995, the federal wage base of \$7,000 would be set equal to the average covered wage, estimated to be \$28,200. In subsequent years, the federal wage base would be indexed to the change in the average covered wage. The minimum wage base for state unemployment taxes would remain at the current-law level of \$7,000. In addition, H.R. 5260 would impose a 0.30 percent net tax rate in 1995 and 1996 and a 0.25 percent tax rate in 1997 and beyond. Together, increasing the wage base and reducing the net tax rate would increase revenues by \$212 million during the 1995 to 1997 period.

Also, this bill would extend the exemption from federal unemployment taxes for certain agricultural workers. Under H.R. 5260, the wages of H-2 agricultural workers, those workers admitted into the U.S. only if domestic workers are not available for the employer's job opportunities, would continue to be exempt from unemployment taxes through December 31, 1994. The current exemption is scheduled to expire after December 31, 1992. CBO estimates that this extension will reduce net revenues by \$1 million in 1993, \$2 million in 1994, and \$1 million in 1995.

Section 305 would delay the reduction of credits against employers' FUTA liabilities in qualifying states by one year. Under current law, states with outstanding unemployment loans from the federal government are required to repay them fully by November 10 of the calendar year in which the second consecutive January 1 passes after the state borrowed funds. The application of the requirement means that a state may have from 22 to 34 months to repay a loan without penalty, depending upon when the loan was obtained. If the loan is not repaid by the appropriate November 10 deadline, the state's employers become subject to a reduction in the credit employers are allowed to take against their FUTA tax liabilities. The reduction begins in the calendar year in which the second consecutive January first passes with a loan outstanding.

UNEMPLOYMENT COMPENSATION EXTENSION

JULY 2, 1992.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 5260]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 5260), to extend the emergency unemployment compensation program, to revise the trigger provisions contained in the extended unemployment compensation program, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Unemployment Compensation Amendments of 1992".

TITLE I—EXTENSION OF EMERGENCY UNEMPLOYMENT COMPENSATION PROGRAM

SEC. 101. EXTENSION OF PROGRAM.

(a) **GENERAL RULE.**—Sections 102(f)(1) and 106(a)(2) of the Emergency Unemployment Compensation Act of 1991 (Public Law 102-164, as amended) are each amended by striking "July 4, 1992" and inserting "March 6, 1993"

(b) **WEEKS OF BENEFITS AVAILABLE DURING EXTENSION.**—Subparagraph (A) of section 102(b)(2) of such Act is amended by striking

(2) **STATE AGENCY.**—For purposes of this subsection, the term “State agency” has the meaning given such term by section 3306(e) of the Internal Revenue Code of 1986.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on October 1, 1992.

SEC. 302. MAILING OF CERTAIN INFORMATION PERMITTED.

(a) **GENERAL RULE.**—Section 302 of the Social Security Act (42 U.S.C. 502) is amended by adding at the end thereof the following new subsection:

“(c) No portion of the cost of mailing a statement under section 6050B(b) of the Internal Revenue Code of 1986 (relating to unemployment compensation) shall be treated as not being a cost for the proper and efficient administration of the State unemployment compensation law by reason of including with such statement information about the earned income credit provided by section 32 of the Internal Revenue Code of 1986. The preceding sentence shall not apply if the inclusion of such information increases the postage required to mail such statement.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 303. EXTENSION OF EXISTING TREATMENT OF CERTAIN AGRICULTURAL WORKERS.

(a) **GENERAL RULE.**—Subparagraph (B) of section 3306(c)(1) of the Internal Revenue Code of 1986 is amended by striking “January 1, 1993” and inserting “January 1, 1995”.

(b) **REPORT.**—Not later than February 1, 1994, the Advisory Council on Unemployment Compensation shall submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on its recommendations with respect to the treatment of agricultural labor performed by aliens.

SEC. 304. EXTENSION OF PERIOD FOR REPAYMENT OF FEDERAL LOANS TO STATE UNEMPLOYMENT FUNDS.

(a) **GENERAL RULE.**—If the Secretary of Labor determines that a State meets the requirements of subsection (b), paragraph (2) of section 3302(c) of the Internal Revenue Code of 1986 shall be applied with respect to such State for taxable years after 1991—

(1) by substituting “third” for “second” in subparagraph (A)(i),

(2) by substituting “fourth or fifth” for “third or fourth” in subparagraph (B), and

(3) by substituting “sixth” for “fifth” in subparagraph (C).

(b) **REQUIREMENTS.**—A State meets the requirements of this subsection if, during calendar year 1992 or 1993, the State amended its unemployment compensation law to increase estimated contributions required under such law by at least 25 percent.

(c) **SPECIAL RULE.**—This section shall not apply to any taxable year after 1994 unless—

(1) such taxable year is in a series of consecutive taxable years as of the beginning of each of which there was a balance referred to in section 3302(c)(2) of such Code, and

(2) such series includes a taxable year beginning in 1992, 1993, or 1994.

TITLE IV—MODIFICATION TO REGULAR STATE UNEMPLOYMENT COMPENSATION PROGRAMS

SEC. 401. TREATMENT OF SHORT-TIME UNEMPLOYMENT COMPENSATION PROGRAMS.

(a) AUTHORIZATION OF PROGRAMS.—

(1) Paragraph (4) of section 3304(a) of the Internal Revenue Code of 1986 is amended by striking “and” at the end of subparagraph (C), by inserting “and” at the end of subparagraph (D) and by adding at the end thereof the following new subparagraph:

“(E) amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor;”

(2) Subsection (f) of section 3306 of such Code is amended by striking “and” at the end of paragraph (2) by striking the period at the end of paragraph (3) and inserting “; and”, and by adding at the end thereof the following new paragraph:

“(4) amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor.”

(3) Section 303(a)(5) of the Social Security Act is amended by inserting before “; and” the following “: Provided further, That amounts may be withdrawn for the payment of short-time compensation under a plan approved by the Secretary of Labor”.

(b) ASSISTANCE IN IMPLEMENTING PROGRAMS.—In order to assist States in establishing and implementing short-time compensation programs—

(1) the Secretary of Labor (hereinafter in this section referred to as the “Secretary”) shall develop model legislative language which may be used by States in developing and enacting short-time compensation programs and shall propose such revisions of such legislative language as may be appropriate, and

(2) the Secretary shall provide technical assistance and guidance in developing, enacting, and implementing such programs. The initial model legislative language referred to in paragraph (1) shall be developed not later than January 1, 1993.

(c) REPORTS.—

(1) INITIAL REPORT.—Not later than January 1, 1995, the Secretary shall submit to the Congress a report on the implementation of this section. Such report shall include an evaluation of short-time compensation programs and shall contain such recommendations as the Secretary may deem advisable.

(2) SUBSEQUENT REPORTS.—After the submission of the report under paragraph (1), the Secretary shall submit such additional reports on the implementation of short-time compensation programs as the Secretary deems appropriate.

(d) DEFINITIONS.—For purposes of this section—

(1) SHORT-TIME COMPENSATION PROGRAM.—The term “short-time compensation program” means a program under which—

(F) Section 6652(h) is amended by striking "section 3405(d)(10)(B)" and inserting "section 3405(e)(10)(B)".

(c) **EXCLUSION FROM INCOME.**—

(1) **QUALIFIED TRUSTS.**—Subsection (e) of section 402 (relating to taxability of beneficiary of employees' trust), as amended by section 521, is amended by adding at the end the following new paragraph:

"(6) **DIRECT TRUSTEE-TO-TRUSTEE TRANSFERS.**—Any amount transferred in a direct trustee-to-trustee transfer in accordance with section 401(a)(31) shall not be includible in gross income for the taxable year of such transfer."

(2) **EMPLOYEE ANNUITIES.**—Subsection (a) of section 403 is amended by adding at the end the following new paragraph:

"(5) **DIRECT TRUSTEE-TO-TRUSTEE TRANSFER.**—Any amount transferred in a direct trustee-to-trustee transfer in accordance with section 401(a)(31) shall not be includible in gross income for the taxable year of such transfer."

(3) **ANNUITY CONTRACTS PURCHASED BY CHARITIES AND PUBLIC SCHOOLS.**—Section 403(b)(10) is amended by adding at the end the following new sentence: "Any amount transferred in a direct trustee-to-trustee transfer in accordance with section 401(a)(31) shall not be includible in gross income for the taxable year of the transfer."

(d) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall apply to distributions after December 31, 1992.

(2) **TRANSITION RULE FOR CERTAIN ANNUITY CONTRACTS.**—If, as of July 1, 1992, a State law prohibits a direct trustee-to-trustee transfer from an annuity contract described in section 403(b) of the Internal Revenue Code of 1986 which was purchased for an employee by an employer which is a State or a political subdivision thereof (or an agency or instrumentality of any 1 or more of either), the amendments made by this section shall not apply to distributions before the earlier of—

(A) 90 days after the first day after July 1, 1992, on which such transfer is allowed under State law, or

(B) January 1, 1994.

SEC. 523. DATE FOR ADOPTION OF PLAN AMENDMENTS.

If any amendment made by this subtitle requires an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after January 1, 1994, if—

(1) during the period after such amendment takes effect and before such first plan year, the plan is operated in accordance with the requirements of such amendment, and

(2) such plan amendment applies retroactively to such period.

Subtitle C—Other Provisions

SEC. 531. MODIFICATIONS TO FEDERAL UNEMPLOYMENT ACCOUNTS.

(a) **MODIFICATIONS TO EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT.**—

(1) **TRANSFERS TO ACCOUNT.**—Paragraph (1) of section 905(b) of the Social Security Act is amended to read as follows—

“(b)(1) Except as provided in paragraph (3), the Secretary of the Treasury shall transfer (as of the close of each month), from the employment security administration account to the extended unemployment compensation account established by subsection (a), an amount determined by him to be equal to the sum of—

“(A) 100 percent of the transfers to the employment security administration account pursuant to section 901(b)(2) during such month on account of liabilities referred to in section 901(b)(1)(B), plus

“(B) 20 percent of the excess of the transfers to such account pursuant to section 901(b)(2) during such month on account of amounts referred to in section 901(b)(1)(A) over the payments during such month from the employment security administration account pursuant to section 901 (b)(3) and (d).

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (B), proper adjustments shall be made in the amounts subsequently transferred.”

(2) **INCREASE IN CEILING.**—Subparagraph (B) of section 905(b)(2) of such Act is amended by striking “three-eighths of 1 percent” and inserting “0.5 percent”.

(b) **REDUCTION OF CEILING ON FEDERAL UNEMPLOYMENT ACCOUNT.**—Paragraph (2) of section 902(a) of such Act is amended by striking “five-eighths of 1 percent” and inserting “0.25 percent”.

(c) **BORROWING BETWEEN FEDERAL ACCOUNTS.**—Title IX of such Act is amended by adding at the end the following new section:

“**BORROWING BETWEEN FEDERAL ACCOUNTS**

“**SEC. 910. (a) IN GENERAL.**—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that—

“(1) the amount in the employment security administration account, Federal unemployment account, or extended unemployment compensation account, is insufficient to meet the anticipated payments from the account,

“(2) such insufficiency may cause such account to borrow from the general fund of the Treasury, and

“(3) the amount in any other such account exceeds the amount necessary to meet the anticipated payments from such other account,

the Secretary shall transfer to the account referred to in paragraph (1) from the account referred to paragraph (3) an amount equal to the insufficiency determined under paragraph (1) (or, if less, the excess determined under paragraph (3)).

“(b) **TREATMENT OF ADVANCE.**—Any amount transferred under subsection (a)—

“(1) shall be treated as a noninterest-bearing repayable advance, and

“(2) shall not be considered in computing the amount in any account for purposes of the application of sections 901(f)(2), 902(b), and 905(b).

“(c) **REPAYMENT.**—Whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount in the account to which an advance is made under subsection (a) exceeds the amount necessary to meet the anticipated payments from the account, the Secretary shall transfer from the account to the account from which the advance was made an amount equal to the lesser of the amount so advanced or such excess.”

(d) **REPEAL OF EXPIRED PROVISIONS.**—

(1) Paragraph (2) of section 901(f) of such Act is amended—

(A) by striking “(A) Except as provided in subparagraph (B), the” and inserting “The”, and

(B) by striking subparagraph (B).

(2) Section 901 of such Act is amended by striking subsection (g).

(3) Subsection (g) of section 904 is amended by striking all of such subsection that follows the 1st sentence.

(e) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) **CHANGES IN CEILING AMOUNTS.**—The amendments made by subsection (a)(2) and (b) shall apply to fiscal years beginning after September 30, 1993.

SEC. 532. REQUIREMENT OF DEPOSITS BY FEDERAL AGENCIES FOR UNEMPLOYMENT BENEFITS.

(a) **GENERAL RULE.**—Subsection (c) of section 8509 of title 5, United States Code, is amended by adding at the end thereof the following new paragraph:

“(3) If any Federal agency does not deposit in the Federal Employees Compensation Account any amount before the date 30 days after the date on which the Secretary of Labor has notified such agency that it is required to so deposit such amount, the Secretary of Labor shall notify the Secretary of the Treasury of the failure to make such deposit and the Secretary of the Treasury shall transfer such amount to the Federal Employees Compensation Account from amounts otherwise appropriated to such Federal agency.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to failures outstanding on the date of the enactment of this Act or at any time thereafter.

SEC. 533. REPORT ON ALLOCATION OF ADMINISTRATIVE FUNDS.

Subsection (a) of section 304 of the Emergency Unemployment Compensation Act of 1991 (Public Law 102-164, as amended) is amended by striking “within the 12-month period beginning on the date of the enactment of this Act” and inserting “before December 31, 1994”.

SEC. 534. EXTENSION OF COMMISSION ON INTERSTATE CHILD SUPPORT.

(a) **IN GENERAL.**—Section 126 of the Family Support Act of 1988 (42 U.S.C. 666 note; 102 Stat. 2355) is amended—

(1) in subsection (d)(2), by striking “May” and inserting “August”; and

(2) in subsection (f)(1), by striking “July 1” and inserting “September 30”.

does not repay fully by the appropriate November 10, employers in the State are subject to annual credit decreases beginning with the preceding January 1 until the loan is repaid fully. Employers must pay the additional taxes resulting from the credit decrease no later than January 31 of the next calendar year.

The credit reduction is at least 0.3 percentage point per year beginning with the calendar year in which the second consecutive January first passes during which the loan is outstanding. There are two potential additional credit decreases during ensuing calendar years in which a State has an outstanding advance: (1) in the calendar years after the third and fourth consecutive January firsts pass, the employers in the State face a decrease by the amount that 2.7 percent exceeds the State's average tax rate on taxable wages in the calendar year to which the decrease applies; (2) in the calendar years in which the fifth through ninth consecutive January firsts pass, the employers face a decrease equal to the higher of the amount in (1) or the amount that the State's 5-year benefit cost rate exceeds the State's average tax rate on taxable wages in the calendar year to which the decrease applies. The 5-year benefit-cost rate is one-fifth of the unemployment benefits paid in the first 5 of the last 5 completed calendar years preceding the calendar year to which the credit decrease applies divided by taxable wages in the last calendar year.

House bill.—The provision extends by one year the grace period for Federal unemployment penalty taxes on employers in States with overdue unemployment loans from the Federal government if the State amended its unemployment insurance law in 1992 or 1993 to increase estimated revenues by at least 25 percent in the first year after enactment of the State legislation.

Effective date: Date of enactment.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

IV. MODIFICATION TO REGULAR STATE UNEMPLOYMENT COMPENSATION PROGRAMS

1. TREATMENT OF SHORT-TIME UNEMPLOYMENT COMPENSATION PROGRAMS

Present law.—All funds withdrawn from the unemployment trust fund of a State must be used solely in payment of unemployment compensation, exclusive of administrative expenses and refunds of erroneously paid sums except: (1) certain authorized disability payments; (2) certain "Reed Act" expenses; (3) authorized health insurance costs; and (4) repayments of overpayments. Short-time compensation is not mentioned explicitly.

A provision enacted in 1982 authorizing such programs has expired. (Short-time compensation programs are programs under which States may pay pro rata benefits to individuals who are working less than full time because their employer has a plan approved by the State agency that provides for a reduction in work hours for employees rather than temporary layoffs.)

House bill.—Clarifies that States may continue to pay short-time compensation.

The provision also requires the Secretary of Labor to develop model State legislation, to update it periodically, to provide technical assistance to the States, and to report to Congress on implementation of short-time compensation.

Senate amendment.—Similar to House bill.

Conference agreement.—The conference agreement follows the House bill and Senate amendment. Also, language is added providing that eligible employees may participate in employer-sponsored training programs to enhance job skills if such programs have been approved by the State agency.

2. BENEFIT INFORMATION REQUIREMENTS

Present law.—No provision.

House bill.—The provision requires employers to give each worker whose employment relationship with the employer is terminated such written information on unemployment insurance eligibility and benefits as is provided by the State agency. Employers must post at places readily accessible to employees such printed statements regarding benefit rights as prescribed by the State agency.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House provision.

V. FINANCING PROVISIONS

1. EXTENSION OF PHASEOUT OF PERSONAL EXEMPTIONS

Present law.—Present law permits a personal exemption deduction from gross income for an individual, the individual's spouse, and each dependent. For 1992, the amount of this deduction is \$2,300 for each exemption claimed. This exemption amount is adjusted for inflation. The deduction for personal exemptions is phased out for taxpayers with adjusted gross income (AGI) above a threshold amount (indexed for inflation), which is based on filing status. For 1992, the threshold amounts are \$157,900 for married taxpayers filing joint returns, \$78,950 for married taxpayers filing separate returns, \$131,550 for unmarried taxpayers filing as head of household, and \$105,250 for unmarried taxpayers filing as single.

The total amount of exemptions which may be claimed by a taxpayer is reduced by 2 percent for each \$2,500 (or portion thereof) by which the taxpayer's AGI exceeds the applicable threshold (the phaseout rate is 4 percent for married taxpayers filing separate returns). Thus, the personal exemptions claimed are phased out over a \$122,500 range, beginning at the applicable threshold.

This provision does not apply to taxable years beginning after December 31, 1995.

House bill.—The bill delays the expiration date for the personal exemption phaseout applicable to higher-income individuals for two years. Under this provision, the phaseout of personal exemptions will not apply to taxable years beginning after December 31, 1997.

Effective date: The provision is effective for taxable years beginning in 1996 and 1997.

Senate amendment.—No provision.

Financial assistance to which the FIRREA amendments apply: The proposal would not apply to any financial assistance to which the amendments made by section 1401(a)(3) of FIRREA apply.

No inference: No inference would be intended as to prior law or as to the treatment of any item to which this proposal does not apply.

Conference agreement.—The conference agreement does not include the Senate provision.

8. TRANSFER OF INCOME TAXES ON UNEMPLOYMENT BENEFITS TO UNEMPLOYMENT TRUST FUND

Present law.—Under present law, all unemployment benefits received are included in a taxpayer's gross income. Tax revenues generated by this provision are deposited, along with almost all individual income tax receipts, in the General Fund of the Treasury.

A portion of social security and tier I railroad retirement benefits is includible in gross income. An individual is required to include in gross income the lesser of: (1) 50 percent of the individual's social security or tier I railroad retirement benefits; or (2) 50 percent of the individual's modified adjusted gross income above a specified threshold. Modified adjusted gross income is defined as the sum of 50 percent of the individual's social security or tier I railroad retirement benefits plus otherwise calculated adjusted gross income plus certain tax-exempt interest. The threshold amounts are \$32,000 for married taxpayers filing joint returns and \$25,000 for unmarried taxpayers.

The Secretary of the Treasury is required to estimate the individual income tax liabilities attributable to the payment of social security and tier I railroad retirement benefits. These proceeds are transferred (credited) quarterly to the Old-Age and Survivors Insurance Trust Fund, the Disability Insurance Trust Fund, or the Railroad Retirement Trust Fund, as appropriate.

House bill.—The bill requires the Secretary of Treasury to estimate the individual income tax liabilities attributable to the receipt of unemployment compensation benefits and transfer the proceeds into the Extended Unemployment Compensation Account of the Unemployment Trust Fund.

Effective date: The provision is effective for all unemployment compensation benefits paid after December 31, 1990.

Senate amendment.—No provision.

Conference agreement.—The conference agreement does not include the House bill provision.

9. MODIFICATIONS TO FEDERAL UNEMPLOYMENT ACCOUNTS

Present law.—Ninety percent of Federal unemployment tax revenue flows into the Employment Security Administration Account (ESAA), which funds the administration of the unemployment insurance and employment services. Ten percent flows into the Extended Unemployment Compensation Account (EUCA), which funds the Extended Benefits (EB) and Emergency Unemployment Compensation (EUC) programs. Each account has a ceiling. The excess over the ceilings flow into the Federal Unemployment Account, which provides loans to insolvent State programs. If all

three accounts overflow, the excess flows to the State accounts in proportion to their share of total wages paid Nationwide.

House bill.—The provision changes the flow of Federal unemployment tax revenue into the three Federal accounts such that the administration account receives 80 percent and the Extended Unemployment Compensation Account (EUCA) receives 20 percent of the annual revenue. Also, it: authorizes interest-free borrowing between accounts; lowers the ceiling in the loan account from 0.625 percent to 0.125 percent of total annual wages; raises the ceiling on the Extended Unemployment Compensation Account (EUCA) from 0.375 percent to 0.625 percent of total annual wages; makes the ceiling changes effective in fiscal year 1994; and retains the current law provision that when all three accounts are full, the excess revenue flows back to the States in proportion to their share of total wages Nationwide.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill with technical changes in the operations of the trust fund accounts. The ceiling in the EUCA would be 0.5 percent and the ceiling in the FUA would be 0.25 percent.

10. REQUIREMENT OF DEPOSITS BY FEDERAL AGENCIES FOR UNEMPLOYMENT BENEFITS

Present law.—No provision.

House bill.—The provision authorizes the Secretary of the Treasury to transfer amounts owed to the Federal Employees Compensation Account from amounts otherwise appropriated to such Federal agency if 30 days have passed since the date on which the Secretary of Labor notified the agency that it was required to deposit such amount.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

11. REPORT ON ALLOCATION OF ADMINISTRATIVE FUNDS

Present law.—The Emergency Unemployment Compensation Act of 1991 authorized a study of the basic method of allocating funds among States for administration of unemployment insurance. The report is due no later than November 17, 1992.

House bill.—The provision changes the due date of the report to December 31, 1994.

Senate amendment.—No provision.

Conference agreement.—The conference agreement follows the House bill.

VI. BUDGETARY TREATMENT

1. TREATMENT UNDER PAY-AS-YOU-GO PROCEDURES

Present law.—New entitlement spending for benefits from the unemployment trust fund is subject to the pay-as-you-go requirements of the Balanced Budget and Deficit Control Act of 1985, as amended. Spending for administration is treated as discretionary

Finder's Aid
P.L. 102-375 (106 Stat. 1195) Approved September 30, 1992
Older Americans Act Amendments of 1992

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>106 Stat.</u>	<u>H. Rep. 102-199</u>	<u>S. Rep. 102-151</u>
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities	1819(c)(2) (B)(iii) (II)	708(a)(1)(A)	1292	-	-
Medicare - Hospital Insurance Benefits - Skilled Nursing Facilities	1819(g)(5) (B)	708(a)(1) (A)	1292	-	-
Medicaid - Requirements for Nursing Facilities	1919(c)(2) (B)(iii) (II)	708(a)(1) (B)	1292	-	-
Medicaid - Requirements for Nursing Facilities	1919(g)(5) (B)	708(a)(1) (B)	1292	-	-

Public Law 102-375
102d Congress

An Act

To amend the Older Americans Act of 1965 to authorize appropriations for fiscal years 1992 through 1995; to authorize a 1993 National Conference on Aging; to amend the Native Americans Programs Act of 1974 to authorize appropriations for fiscal years 1992 through 1995; and for other purposes.

Sept. 30, 1992
[H.R. 2967]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Older Americans Act Amendments of 1992”.

(b) TABLE OF CONTENTS.—The table of contents is as follows:

Sec. 1. Short title; table of contents.

TITLE I—OBJECTIVES AND DEFINITIONS

Sec. 101. Objectives.

Sec. 102. Definitions.

TITLE II—ADMINISTRATION

Sec. 201. Administration on Aging.

Sec. 202. Functions of Commissioner.

Sec. 203. Federal agency consultation.

Sec. 204. Consultation with State agencies, area agencies on aging, and Native American grant recipients.

Sec. 205. Federal Council on the Aging.

Sec. 206. Nutrition officer.

Sec. 207. Evaluation.

Sec. 208. Reports.

Sec. 209. Nutrition education.

Sec. 210. Authorization of appropriations.

Sec. 211. Study of effectiveness of State long-term care ombudsman programs.

Sec. 212. Study on board and care facility quality.

Sec. 213. Study on home care quality.

TITLE III—STATE AND COMMUNITY PROGRAMS ON AGING

Sec. 301. Purpose of grants for State and community programs on aging.

Sec. 302. Definitions.

Sec. 303. Authorization of appropriations; uses of funds.

Sec. 304. Allotment; Federal share.

Sec. 305. Organization.

Sec. 306. Area plans.

Sec. 307. State plans.

Sec. 308. Planning, coordination, evaluation, and administration of State plans.

Sec. 309. Disaster relief reimbursements.

Sec. 310. Availability of surplus commodities.

Sec. 311. Rights relating to in-home services for frail older individuals.

Sec. 312. Supportive services.

Sec. 313. Congregate nutrition services.

Sec. 314. Home delivered nutrition services.

Sec. 315. Criteria.

Sec. 316. School-based meals for volunteer older individuals and multigenerational programs.

Sec. 317. Dietary guidelines; payment requirement.

Sec. 318. In-home services.

Sec. 319. Preventive health services.

Sec. 320. Supportive activities for caretakers who provide in-home services to frail older individuals.

TITLE IV—TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS

Sec. 401. Statement of purpose.

Older
Americans Act
Amendments of
1992.
42 USC 3001
note.

- Sec. 402. Priorities for grants and discretionary projects.
- Sec. 403. Purposes of education and training projects.
- Sec. 404. Grants and contracts.
- Sec. 405. Multidisciplinary centers of gerontology.
- Sec. 406. Demonstration projects.
- Sec. 407. Special projects in comprehensive long-term care.
- Sec. 408. Ombudsman and advocacy demonstration projects.
- Sec. 409. Demonstration projects for multigenerational activities.
- Sec. 410. Supportive services in federally assisted housing demonstration program.
- Sec. 411. Neighborhood senior care program.
- Sec. 412. Information and assistance systems development projects.
- Sec. 413. Senior transportation demonstration program grants.
- Sec. 414. Resource Centers on Native American Elders.
- Sec. 415. Demonstration programs for older individuals with developmental disabilities.
- Sec. 416. Housing demonstration programs.
- Sec. 417. Private resource enhancement projects.
- Sec. 418. Career preparation for the field of aging.
- Sec. 419. Pension information and counseling demonstration projects.
- Sec. 420. Authorization of appropriations.
- Sec. 421. Payments of grants for demonstration projects.
- Sec. 422. Responsibilities of Commissioner.

TITLE V—COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

- Sec. 501. Older American Community Service Employment Program.
- Sec. 502. Coordination.
- Sec. 503. Interagency cooperation.
- Sec. 504. Equitable distribution of assistance.
- Sec. 505. Authorization of appropriations.
- Sec. 506. Dual eligibility.
- Sec. 507. Treatment of assistance provided under the Older American Community Service Employment Act.

TITLE VI—GRANTS FOR NATIVE AMERICANS

- Sec. 601. Applications by tribal organizations.
- Sec. 602. Distribution of funds among tribal organizations.
- Sec. 603. Applications by organizations serving Native Hawaiians.
- Sec. 604. Distribution of funds among organizations.
- Sec. 605. Authorization of appropriations.

TITLE VII—VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES

- Sec. 701. Allotments for vulnerable elder rights protection activities.
- Sec. 702. Ombudsman programs.
- Sec. 703. Programs for prevention of elder abuse, neglect, and exploitation.
- Sec. 704. State elder rights and legal assistance development program.
- Sec. 705. Outreach, counseling, and assistance programs.
- Sec. 706. Native American organization provisions.
- Sec. 707. General provisions.
- Sec. 708. Technical and conforming amendments.

TITLE VIII—AMENDMENTS TO OTHER LAWS; RELATED MATTERS

Subtitle A—Long-Term Health Care Workers

- Sec. 801. Definitions.
- Sec. 802. Information requirements.
- Sec. 803. Reports.
- Sec. 804. Occupational code.

Subtitle B—National School Lunch Act

- Sec. 811. Meals provided through adult day care centers.

Subtitle C—Native American Programs

- Sec. 821. Short title.
- Sec. 822. Amendments.

Subtitle D—White House Conference on Aging

- Sec. 831. White House Conference on Aging.
- Sec. 832. Conference required.
- Sec. 833. Conference administration.
- Sec. 834. Policy committee; related committees.

- Sec. 335. Report of the conference.
- Sec. 336. Authorization of appropriations.
- Sec. 337. Savings provision.
- Sec. 338. Sense of the Congress.
- Sec. 339. Technical amendments.

TITLE IX—GENERAL PROVISIONS

- Sec. 901. Limitation on authority to enter into contracts.
- Sec. 902. Regulations.
- Sec. 903. Sense of Congress.
- Sec. 904. Technical amendments.
- Sec. 905. Effective dates; application of amendments.

TITLE I—OBJECTIVES AND DEFINITIONS

SEC. 101. OBJECTIVES.

Section 101(4) of the Older Americans Act of 1965 (42 U.S.C. 3001(4)) is amended by inserting “, including support to family members and other persons providing voluntary care to older individuals needing long-term care services” after “homes”.

SEC. 102. DEFINITIONS.

(a) IN GENERAL.—Section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002) is amended by adding at the end the following:

“(13) The term ‘abuse’ means the willful—

“(A) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish; or

“(B) deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.

“(14) The term ‘Administration’ means the Administration on Aging.

“(15) The term ‘adult child with a disability’ means a child who—

“(A) is 18 years of age or older;

“(B) is financially dependent on an older individual who is a parent of the child; and

“(C) has a disability.

“(16) The term ‘aging network’ means the network of—

“(A) State agencies, area agencies on aging, title VI grantees, and the Administration; and

“(B) organizations that—

“(i)(I) are providers of direct services to older individuals; or

“(II) are institutions of higher education; and

“(ii) receive funding under this Act.

“(17) The term ‘area agency on aging’ means an area agency on aging designated under section 305(a)(2)(A) or a State agency performing the functions of an area agency on aging under section 305(b)(5).

“(18) The term ‘art therapy’ means the use of art and artistic processes specifically selected and administered by an art therapist, to accomplish the restoration, maintenance, or improvement of the mental, emotional, or social functioning of an older individual.

“(1) an Indian tribe; or

“(2) a public agency, or a nonprofit organization, serving older individuals who are Native Americans.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$5,000,000 for fiscal year 1992, and such sums as may be necessary for fiscal years 1993, 1994, and 1995.”.

SEC. 707. GENERAL PROVISIONS.

Title VII of the Older Americans Act of 1965 (as added by section 701, and amended by the preceding sections) is amended by adding at the end the following:

“Subtitle C—General Provisions

“SEC. 761. DEFINITIONS.

42 USC 3058b.

“As used in this title:

“(1) ELDER RIGHT.—The term ‘elder right’ means a right of an older individual.

“(2) VULNERABLE ELDER RIGHTS PROTECTION ACTIVITY.—The term ‘vulnerable elder rights protection activity’ means an activity funded under chapter 2, 3, 4, or 5 of this title.

“SEC. 762. ADMINISTRATION.

42 USC 3058cc.

“A State agency or an entity described in section 751(c) may carry out vulnerable elder rights protection activities either directly or through contracts or agreements with public or nonprofit private agencies or organizations, such as—

“(1) other State agencies;

“(2) area agencies on aging;

“(3) county governments;

“(4) institutions of higher education;

“(5) Indian tribes; or

“(6) nonprofit service providers or volunteer organizations.

“SEC. 763. TECHNICAL ASSISTANCE.

42 USC 3058dd.

“(a) OTHER AGENCIES.—In carrying out the provisions of this title, the Commissioner may request the technical assistance and cooperation of such Federal entities as may be appropriate.

“(b) COMMISSIONER.—The Commissioner shall provide technical assistance and training (by contract, grant, or otherwise) to persons and entities that administer programs established under this title.

“SEC. 764. AUDITS.

42 USC 3058ee.

“(a) ACCESS.—The Commissioner, the Comptroller General of the United States, and any duly authorized representative of the Commissioner or the Comptroller shall have access, for the purpose of conducting an audit or examination, to any books, documents, papers, and records that are pertinent to financial assistance received under this title.

“(b) LIMITATION.—State agencies, area agencies on aging, and entities described in section 751(c) shall not request information or data from providers that is not pertinent to services furnished under this title or to a payment made for the services.”.

SEC. 708. TECHNICAL AND CONFORMING AMENDMENTS.

(a) OMBUDSMAN PROGRAM.—

(1) SOCIAL SECURITY ACT.—

(A) Section 1819 of the Social Security Act (42 U.S.C. 1395i-3) is amended in subsections (c)(2)(B)(iii)(II) and (g)(5)(B) by striking “established under section 307(a)(12) of the Older Americans Act of 1965” and inserting “established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act”.

(B) Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended in subsections (c)(2)(B)(iii)(II) and (g)(5)(B) by striking “established under section 307(a)(12) of the Older Americans Act of 1965” and inserting “established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act”.

(2) OLDER AMERICANS ACT OF 1965.—

(A) Section 207(b) of the Older Americans Act of 1965 (42 U.S.C. 3018(b)) is amended—

(i) in paragraph (1)(A), by striking “section 307(a)(12)(C)” and inserting “titles III and VII in accordance with section 712(c)”; and

(ii) in paragraph (3)—

(I) by striking “by section 307(a)(12)(H)(i)” and inserting “under titles III and VII in accordance with section 712(h)(1)”; and

(II) by striking subparagraph (E) and inserting the following:

“(E) each public agency or private organization designated as an Office of the State Long-Term Care Ombudsman under title III or VII in accordance with section 712(a)(4)(A).”

(B) Section 301(c) of the Older Americans Act of 1965 (42 U.S.C. 3021(c)) is amended by striking “section 307(a)(12), and to individuals designated under such section” and inserting “section 307(a)(12) in accordance with section 712, and to individuals within such programs designated under section 712”.

(C) Section 351(4) of the Older Americans Act of 1965 (42 U.S.C. 3030l(4)) is amended by striking “section 307(a)(12)” and inserting “titles III and VII in accordance with section 712”.

(b) PROGRAMS FOR PREVENTION OF ABUSE, NEGLECT, AND EXPLOITATION.—Section 321(15) of the Older Americans Act of 1965 (42 U.S.C. 3030d(15)) is amended by striking “clause (16) of section 307(a)” and inserting “chapter 3 of subtitle A of title VII and section 307(a)(16)”.

(c) OUTREACH PROGRAMS.—

(1) Section 202(a)(20) of the Older Americans Act of 1965 (42 U.S.C. 3012(a)(20)) is amended by striking “under section 307(a)(31)”.

(2) Section 207(c) of the Older Americans Act of 1965 (42 U.S.C. 3018(c)) is amended—

(A) in the first sentence, by striking “on the evaluations required to be submitted under section 307(a)(31)(D)” and inserting “on the outreach activities supported under this Act”; and

(B) in paragraph (1), by striking “outreach activities supported under section 306(a)(6)(P)” and inserting “the activities”.

(5) INDIAN AND NATIVE HAWAIIAN PROGRAMS.—The amendments made by sections 601 and 603 shall not apply with respect to fiscal year 1992.

(6) VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES.—The amendments made by title VII shall not apply with respect to fiscal year 1992.

Approved September 30, 1992.

LEGISLATIVE HISTORY—H.R. 2967 (S. 243) (S. 3008):

HOUSE REPORTS: No. 102-199 (Comm. on Education and Labor).

SENATE REPORTS: No. 102-151 accompanying S. 243 (Comm. on Labor and Human Resources).

CONGRESSIONAL RECORD:

Vol. 137 (1991): Sept. 12, considered and passed House.

Nov. 12, considered and passed Senate, amended, in lieu of S. 243.

Vol. 138 (1992): Apr. 9, House agreed to Senate amendment with an amendment.

Sept. 15, Senate concurred in House amendment with an amendment.

Sept. 22, House concurred in Senate amendment.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 28 (1992):

Sept. 30, Presidential statement.

Finder's Aid
P.L. 102-585 (106 Stat. 6943) Approved November 4, 1992
Veterans Health Care Act of 1992

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>106 Stat.</u>	<u>S.Rep. 102-401</u>
Medicaid - Payment for Covered Outpatient Drugs	1927(a)(1)	601(b)(1)	4962	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(a)(5) New	601(b)(2)	4962	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(a)(6) New	601(b)(2)	4962	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(b)(3) (b)	601(b)(3) (A)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(b)(3) (b)	601(b)(3) (B)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(b)(3) (D)	601(b)(3) (C)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(b)(4) (B)(ii)	601(b)(4) (i)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(b)(4) (B)(ii)	601(b)(4) (ii)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(b)(4) (iv) New	601(b)(4) (iii)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(b)(4) (v) New	601(b)(4) (iii)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(c)(1) (B)(i)	601(c)(1)	4964	61-72

P.L. 102-585

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>106 Stat.</u>	<u>S.Rep. 102-401</u>
Medicaid - Payment for Covered Outpatient Drugs (technical amendment)	1927(c)(1) (B)(i)	601(c)(2)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(c)(1) (B)(ii)	601(c)(3)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(c)(1) (B)(iii) New	601(c)(3)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(c)(1) (B)(iv) New	601(c)(3)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(c)(1) (B)(v) New	601(c)(3)	4964	61-72
Medicaid - Payment for Covered Outpatient Drugs	1927(c)(1) (C)	601(a)	4962	61-72

Public Law 102-585
102d Congress

An Act

To amend title 38, United States Code, to improve health care services for women veterans, to expand authority for health care sharing agreements between the Department of Veterans Affairs and the Department of Defense to revise certain pay authorities that apply to Department of Veterans Affairs nurses, to improve preventive health services for veterans, to establish discounts on pharmaceuticals purchased by the Department of Veterans Affairs, to provide for a Persian Gulf War Veterans Health Registry, and to make other improvements in the delivery and administration of health care by the Department of Veterans Affairs.

Nov. 4, 1992
[H.R. 5193]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Veterans Health Care Act of 1992”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Veterans
Health Care
Act of 1992.
38 USC 101
note.

Sec. 1. Short title; table of contents.

Sec. 2. References to title 38, United States Code.

TITLE I—WOMEN VETERANS HEALTH PROGRAMS

Sec. 101. Short title.

Sec. 102. Sexual trauma counseling.

Sec. 103. Priority for outpatient care for sexual trauma counseling.

Sec. 104. Commencement of provision of information on services.

Sec. 105. Report on implementation of sexual trauma counseling program.

Sec. 106. Health care services for women.

Sec. 107. Report on health care and research.

Sec. 108. Coordination of services.

Sec. 109. Research relating to women veterans health.

Sec. 110. Population study of women veterans.

TITLE II—HEALTH-CARE SHARING AGREEMENTS BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE

Sec. 201. Temporary expansion of authority for sharing agreements.

Sec. 202. Requirement for improvement in services for veterans.

Sec. 203. Expanded sharing agreements with Department of Defense.

Sec. 204. Expiration of authority.

Sec. 205. Consultation with veterans service organizations.

Sec. 206. Annual report.

TITLE III—NURSE PAY

Sec. 301. Revision to nurse pay grade schedule.

Sec. 302. Authority to establish special rates of pay for employees of facilities located outside the contiguous United States, Alaska, and Hawaii.

Sec. 303. Salary data for nurse anesthetists.

Sec. 304. Rates of pay for transferring nurses.

Sec. 305. Nursing personnel qualification standards.

Sec. 306. Report on pay for chief nurse position.

Sec. 307. Report on pay compression.

Sec. 308. Effective date.

TITLE IV—STATE HOME AMENDMENTS

Sec. 401. Treatment of earnings of veterans under certain rehabilitative services programs.

Sec. 402. Permanent authority to make grants to States relating to State homes.

- Sec. 403. Extension of period for completion of conditionally approved applications for construction.
- Sec. 404. Limited prohibition on obligation of funds for rescinded projects.
- Sec. 405. Commencement date for recapture period.
- Sec. 406. Commencement date for payment of per diem.

TITLE V—GENERAL HEALTH CARE AND ADMINISTRATION

Subtitle A—General Health

- Sec. 501. Contract hospital care for veterans with permanent and total service-connected disabilities.
- Sec. 502. Permanent authority for respite care program.
- Sec. 503. Extension of authority to contract with the Veterans Memorial Medical Center, Republic of the Philippines.

Subtitle B—Preventive Health

- Sec. 511. National Center for Preventive Health.
- Sec. 512. Annual report on preventive health services.
- Sec. 513. Preventive health services.
- Sec. 514. Repeal of pilot program.

Subtitle C—Health Care Administration and Personnel

- Sec. 521. Geriatric research, education, and clinical centers.
- Sec. 522. Extension of authority to waive certain limitations applicable to receipt of retirement pay by nurses.
- Sec. 523. Health professionals education programs.
- Sec. 524. Real property at Temple Junior College, Temple, Texas.
- Sec. 525. Demonstration project to evaluate installation of telephones for patient use at Department health-care facilities.
- Sec. 526. Use of Tobacco Products in Department Facilities.

TITLE VI—DRUG PRICING AGREEMENTS

- Sec. 601. Treatment of prescription drugs procured by Department of Veterans Affairs or purchased by certain clinics and hospitals.
- Sec. 602. Limitations on prices of drugs purchased by certain clinics and hospitals.
- Sec. 603. Limitation on prices of drugs procured by Department of Veterans Affairs and certain other Federal agencies.

TITLE VII—PERSIAN GULF WAR VETERANS' HEALTH STATUS

- Sec. 701. Short title.
- Sec. 702. Persian Gulf War Veterans Health Registry.
- Sec. 703. Health examinations and counseling for veterans eligible for inclusion in certain health-related registries.
- Sec. 704. Expansion of coverage of Persian Gulf Registry.
- Sec. 705. Study by Office of Technology Assessment of Persian Gulf Registry and Persian Gulf War Veterans Health Registry.
- Sec. 706. Agreement with National Academy of Sciences for review of health consequences of service during the Persian Gulf War.
- Sec. 707. Coordination of government activities on health-related research on the Persian Gulf War.
- Sec. 708. Definition.

TITLE VIII—COURT OF VETERANS APPEALS

- Sec. 801. Disciplinary procedures for judges of Court of Veterans Appeals.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—WOMEN VETERANS HEALTH PROGRAMS

SEC. 101. SHORT TITLE.

This title may be cited as the "Women Veterans Health Programs Act of 1992".

The report shall include a description of the actions taken at each covered facility to ensure compliance with this section.

(d) **EFFECTIVE DATE.**—The requirement to establish and maintain areas for smoking under subsection (a) shall take effect 60 days after the date on which the Comptroller General submits to the committees referred to in subsection (c)(1) that report required under that subsection.

TITLE VI—DRUG PRICING AGREEMENTS

SEC. 801. TREATMENT OF PRESCRIPTION DRUGS PROCURED BY DEPARTMENT OF VETERANS AFFAIRS OR PURCHASED BY CERTAIN CLINICS AND HOSPITALS.

(a) **EXCLUSION OF PRICES FROM CALCULATION OF BEST PRICES FOR MEDICAID REBATE AGREEMENTS.**—Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(C)) is amended by striking “(excluding)” and inserting “(excluding any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, United States Code, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B), any prices charged under the Federal Supply Schedule of the General Services Administration, or any prices used under a State pharmaceutical assistance program, and excluding”.

(b) **AGREEMENTS REQUIRED TO RECEIVE PAYMENT.**—

(1) **IN GENERAL.**—The first sentence of section 1927(a)(1) of such Act (42 U.S.C. 1396r-8(a)(1)) is amended by striking “manufacturer.” and inserting “manufacturer”, and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after the date of the enactment of title VI of the Veterans Health Care Act of 1992) and paragraph (6).”

(2) **AGREEMENTS DESCRIBED.**—Section 1927(a) of such Act (42 U.S.C. 1396r-8(a)) is amended by adding at the end the following new paragraphs:

“(5) **LIMITATION ON PRICES OF DRUGS PURCHASED BY COVERED ENTITIES.**—

“(A) **AGREEMENT WITH SECRETARY.**—A manufacturer meets the requirements of this paragraph if the manufacturer has entered into an agreement with the Secretary that meets the requirements of section 340B of the Public Health Service Act with respect to covered outpatient drugs purchased by a covered entity on or after the first day of the first month that begins after the date of the enactment of this paragraph.

“(B) **COVERED ENTITY DEFINED.**—In this subsection, the term ‘covered entity’ means an entity described in section 340B(a)(4) of the Public Health Service Act.

“(C) **ESTABLISHMENT OF ALTERNATIVE MECHANISM TO ENSURE AGAINST DUPLICATE DISCOUNTS OR REBATES.**—If the Secretary does not establish a mechanism under section 340B(a)(5)(A) of the Public Health Service Act within 12 months of the date of the enactment of such section, the following requirements shall apply:

“(i) ENTITIES.—Each covered entity shall inform the single State agency under section 1902(a)(5) when it is seeking reimbursement from the State plan for medical assistance described in section 1905(a)(12) with respect to a unit of any covered outpatient drug which is subject to an agreement under section 340B(a) of such Act.

“(ii) STATE AGENCY.—Each such single State agency shall provide a means by which a covered entity shall indicate on any drug reimbursement claims form (or format, where electronic claims management is used) that a unit of the drug that is the subject of the form is subject to an agreement under section 340B of such Act, and not submit to any manufacturer a claim for a rebate payment under subsection (b) with respect to such a drug.

“(D) EFFECT OF SUBSEQUENT AMENDMENTS.—In determining whether an agreement under subparagraph (A) meets the requirements of section 340B of the Public Health Service Act, the Secretary shall not take into account any amendments to such section that are enacted after the enactment of title VI of the Veterans Health Care Act of 1992.

“(E) DETERMINATION OF COMPLIANCE.—A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 340B of the Public Health Service Act (as in effect immediately after the enactment of this paragraph) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after the date of the enactment of this paragraph.

“(6) REQUIREMENTS RELATING TO MASTER AGREEMENTS FOR DRUGS PROCURED BY DEPARTMENT OF VETERANS AFFAIRS AND CERTAIN OTHER FEDERAL AGENCIES.—

“(A) IN GENERAL.—A manufacturer meets the requirements of this paragraph if the manufacturer complies with the provisions of section 8126 of title 38, United States Code, including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section.

“(B) EFFECT OF SUBSEQUENT AMENDMENTS.—In determining whether a master agreement described in subparagraph (A) meets the requirements of section 8126 of title 38, United States Code, the Secretary shall not take into account any amendments to such section that are enacted after the enactment of title VI of the Veterans Health Care Act of 1992.

“(C) DETERMINATION OF COMPLIANCE.—A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 8126 of title 38, United States Code (as in effect immediately after the enactment of this paragraph) and would have entered

into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after the date of the enactment of this paragraph.”.

(3) **CONFIDENTIALITY OF INFORMATION.**—Section 1927(b)(3)(D) of such Act (42 U.S.C. 1396r-8(b)(3)(D)) is amended—

(A) by striking “this paragraph” and inserting “this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A)(ii)”;

(B) by striking “Secretary” each place it appears and inserting “Secretary or the Secretary of Veterans Affairs”; and

(C) by striking “except” and all that follows through the period and inserting: “except—

“(i) as the Secretary determines to be necessary to carry out this section,

“(ii) to permit the Comptroller General to review the information provided, and

“(iii) to permit the Director of the Congressional Budget Office to review the information provided.”.

(4) **TERMINATION OF REBATE AGREEMENTS.**—Section 1927(b)(4)(B) of such Act (42 U.S.C. 1396r-8(b)(4)(B)) is amended—

(i) in clause (ii), by striking “such period” and inserting “the calendar quarter beginning at least 60 days”,

(ii) in clause (ii), by striking “of the notice” and all through “the agreement).” and inserting “the manufacturer provides notice to the Secretary.”, and

(iii) by adding at the end the following new clauses:

“(iv) **NOTICE TO STATES.**—In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

“(v) **APPLICATION TO TERMINATIONS OF OTHER AGREEMENTS.**—The provisions of this subparagraph shall apply to the terminations of agreements described in section 340B(a)(1) of the Public Health Service Act and master agreements described in section 8126(a) of title 38, United States Code.”.

(c) **BUDGET NEUTRALITY ADJUSTMENT.**—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(B)) is amended—

(1) by striking “January 1, 1993,” and inserting “October 1, 1992.”;

(2) by striking “and” at the end of clause (i); and

(3) by striking clause (ii) and inserting the following:

“(ii) for quarters (or other periods) beginning after September 30, 1992, and before January 1, 1994, the greater of—

“(I) 15.7 percent of the average manufacturer price for the drug, or

“(II) the difference between the average manufacturer price for the drug and the best price (as defined in subparagraph (C)) for such quarter (or period) for such drug;

“(iii) for quarters (or other periods) beginning after December 31, 1993, and before January 1, 1995, the greater of—

“(I) 15.4 percent of the average manufacturer price for the drug, or

“(II) the difference between the average manufacturer price for the drug and the best price (as defined in subparagraph (C)) for such quarter (or period) for such drug;

“(iv) for quarters (or other periods) beginning after December 31, 1994, and before January 1, 1996, the greater of—

“(I) 15.2 percent of the average manufacturer price for the drug, or

“(II) the difference between the average manufacturer price for the drug and the best price (as defined in subparagraph (C)) for such quarter (or period) for such drug; and

“(v) for quarters (or other periods) beginning after December 31, 1995, the greater of—

“(I) 15.1 percent of the average manufacturer price for the drug, or

“(II) the difference between the average manufacturer price for the drug and the best price (as defined in subparagraph (C)) for such quarter (or period) for such drug.”.

(d) **REPORTS ON BEST PRICE CHANGES AND PAYMENT OF REBATES.—**

42 USC 1396r-8
note.

(1) **IN GENERAL.**—Not later than 90 days after the expiration of each calendar quarter that begins on or after October 1, 1992, and ends on or before December 31, 1995, the Secretary of Health and Human Services shall submit a report to Congress that contains the following information relating to prescription drugs dispensed in the quarter (subject to paragraph (2)):

(A) With respect to single source drugs and innovator multiple source drugs (as such terms are defined in section 1927(k)(7) of the Social Security Act)—

(i) the percentage of such drugs whose best price (as reported to the Secretary under section 1927(b) of the Social Security Act) increased compared to the best price during the previous calendar quarter, and the amount of expenditures under State plans under title XIX of such Act attributable to such drugs;

(ii) the percentage of such drugs whose best price (as so reported) decreased compared to the best price during the previous calendar quarter, and the amount of expenditures under State plans under title XIX of such Act attributable to such drugs;

(iii) the percentage of such drugs whose best price (as so reported) was the same as the best price during the previous calendar quarter, and the amount of expenditures under State plans under title XIX of such Act attributable to such drugs;

(iv) the median and mean percentage increase (or decrease) in the best price of such single source drugs (as so reported) compared to the best price during

the previous calendar quarter, unweighted and weighted (in the case of the mean percentage increase or decrease) by the dollar volume of drugs dispensed;

(v) the median and mean percentage increase (or decrease) in the best price of such innovator multiple source drugs (as so reported) compared to the best price during the previous calendar quarter, unweighted and weighted (in the case of the mean percentage increase or decrease) by the dollar volume of drugs dispensed; and

(vi) the median and mean percentage increase (or decrease) in the best price of all such drugs (as so reported) compared to the best price during the previous calendar quarter, unweighted and weighted (in the case of the mean percentage increase or decrease) by the dollar volume of drugs dispensed.

(B) With respect to all drugs for which manufacturers are required to pay rebates under section 1927(c) of the Social Security Act, the Secretary's estimate, on a State-by-State and a national aggregate basis, of—

(i) the total amount of all rebates paid under such section during the quarter, broken down by the portions of such total amount attributable to rebates described in paragraphs (1), (2), and (3) of such section;

(ii) the percentages of such total amount attributable to rebates described in paragraphs (1), (2), and (3) of such section; and

(iii) the amount of the portion of such total amount attributable to the rebate described in paragraph (1) of such section that is solely attributable to the application of subclause (II) of clause (i), (ii), (iii), (iv), or (v) of such paragraph.

(2) **LIMITATION ON DRUGS SUBJECT TO REPORT.**—No report submitted under paragraph (1) shall include any information relating to any prescription drug unless the Secretary finds that expenditures for the drug are significant expenditures under the medicaid program. In the previous sentence, expenditures for a drug are "significant" if the drug was one of the 1,000 drugs for which the greatest amount of the Federal financial assistance attributable to prescription drugs was paid under section 1903(a) of the Social Security Act during calendar year 1991.

(3) **SPECIAL RULE FOR INITIAL REPORT.**—For purposes of the first report required to be submitted under paragraph (1)—

(A) the Secretary shall submit the report not later than May 1, 1993; and

(B) the information contained in the report shall include information on prescription drugs dispensed during each calendar quarter that began on or after January 1, 1991, and ended on or before December 31, 1992.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to payments to State plans under title XIX of the Social Security Act for calendar quarters (or periods) beginning on or after January 1, 1993 (without regard to whether or not regulations to carry out such amendments have been promulgated by such date).

“(B) The Court shall have the power provided under section 372(c)(16) of title 28 to award reimbursement for the reasonable expenses described in that section. Reimbursements under this subparagraph shall be made from funds appropriated to the Court.”.

Approved November 4, 1992.

LEGISLATIVE HISTORY—H.R. 5193 (S. 2575):

HOUSE REPORTS: No. 102-714, Pt. 1 (Comm. on Veterans' Affairs).

SENATE REPORTS: No. 102-401 accompanying S. 2575 (Comm. on Veterans' Affairs).

CONGRESSIONAL RECORD, Vol. 138 (1992):

Aug. 4, considered and passed House.

Oct. 1, considered and passed Senate, amended, in lieu of S. 2575.

Oct. 5, House concurred in Senate amendments with amendments.

Oct. 8, Senate concurred in House amendments.

102D CONGRESS
2d Session

SENATE

REPORT
102-401

VETERANS HEALTH PROGRAMS
IMPROVEMENT ACT
OF 1992

REPORT
OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

TO ACCOMPANY

S. 2575



SEPTEMBER 15 (legislative day, SEPTEMBER 8), 1992.—Ordered to be
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TITLE VI—PROCUREMENT OF PHARMACEUTICALS

Title VI of the Committee bill, which was added by an amendment offered at the Committee's meeting on August 7, 1992, by Senators Rockefeller, Simpson, Murkowski, and Cranston to S. 2575 (as ordered reported by the Committee on June 24, 1992), would (1) require manufacturers of drugs and biologicals to enter into master agreements with the Administrator of the General Services Administration under which the manufacturers who wish to sell their products to any federal entity or any entity receiving Public Health Service (PHS) funds or to receive Medicaid reimbursement agree to participate in the Medicaid outpatient prescription drug rebate program and to sell drugs and biologicals through the Federal Supply Schedule (FSS), Department of Veterans Affairs (VA) depots, and Department of Defense (DoD) depots at prices determined under minimum percentage discount mechanisms established in this legislation; (2) establish mechanisms that would limit increases in FSS, VA depot, and DoD depot prices to rates no greater than increases in the Producer Price Index-Finished Goods; (3) permit State Veterans Homes to purchase drugs and biologicals listed on the FSS at prices no greater than FSS prices; and (4) authorize VA to negotiate unified pharmaceutical award contracts for use by other Federal, State and local government programs, as well as VA itself.

Background

Impact of Medicaid's best-price rebate mechanism on VA's costs

On November 5, 1990, legislation enacted in section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) established the Medicaid outpatient prescription rebate program. That legislation, derived from S. 3029 of the 101st Congress, introduced by Senator David Pryor, and H.R. 5589 of the 101st Congress, introduced by Representatives Ron Wyden and Jim Cooper, requires pharmaceutical manufacturers to provide to State Medicaid programs rebates on reimbursement for drugs and biologicals dispensed to Medicaid beneficiaries on an outpatient basis equal to the larger of (1) a fixed percentage discount from the average manufacturer price, or (2) the difference between the average manufacturer price for each of their products and the "best-prices" charged to any other purchaser. As Senator Pryor noted in his introductory statement on S. 3029, the purpose of the legislation was to reduce the approximately \$5 billion in annual State and federal expenditures for Medicaid outpatient prescription drugs. 136 Cong. Rec. S12954 (daily ed. Sept. 12, 1990). The Congressional Budget Office estimates that the rebate program yielded \$176 million in savings in federal Medicaid costs during fiscal year 1991 and will yield \$705 million in such savings during fiscal year 1992.

Unfortunately, the establishment of the Medicaid rebate program also resulted in unintended, adverse consequences for the Department of Veterans Affairs' health-care program as well as other federal health-care programs. Since the enactment of OBRA 90, FSS prices have increased dramatically. These price increases are

due, at least in part, to some manufacturers' efforts to avoid having to provide State Medicaid programs—through the best-price mechanism—prices as low as pre-OBRA 90 FSS prices. In addition, prices for many drugs and biologicals purchased through VA depots also have increased significantly, even though these depot prices are exempt from Medicaid best-price rebate calculations.

Prior to the enactment of OBRA 90, prices charged to the federal government for many drugs and biologicals purchased through the FSS were among the lowest prices charged to any purchasers in the United States. Two major factors appear to have accounted for manufacturers' pricing practices. First, manufacturers wanted physicians in training to become familiar with their products. According to the Association of American Medical Colleges, each year more than 30,000 medical residents and 22,000 medical students receive a portion of their training in a VA health-care facility. Because physicians' prescribing habits are shaped during their training, manufacturers had an incentive to negotiate significant discounts for FSS prices in order to ensure that VA facilities stocked their products. Second, because FSS sales constitute a small percentage of the total U.S. market—approximately 1.5 percent—many manufacturers negotiated deep discounts for FSS prices in anticipation of the generation of greater sales by physicians who prescribed their products during training. This practice has been a particularly effective tool for marketing brand name drugs for which therapeutic and generic equivalents are available. However, since the enactment of OBRA 90, many manufacturers have ceased this practice because they do not want to provide Medicaid—which accounts for approximately 13 percent of the U.S. market for pharmaceuticals—with prices as low as pre-OBRA 90 FSS prices.

VA uses several mechanisms for purchasing drugs and biologicals. The most widely used is the FSS, a published list of drugs and biologicals available at prices negotiated with manufacturers by VA under authority delegated to VA by the General Services Administration. According to VA officials, FSS purchases account for approximately 50 percent of VA's expenditures for drugs and biologicals. Health-care facilities operated by the Department of Defense, the Bureau of Prisons, and the Public Health Service, including Indian Health Service facilities, have authority to purchase drugs and biologicals through FSS and regularly do so, because FSS prices historically have been much lower than open market prices for most drugs and biologicals.

A second mechanism VA uses is its depot system, which accounts for approximately 25 percent of VA's total expenditures for drugs and biologicals. As part of this system, VA operates three large warehouses at which drugs and biologicals and other medical items are stored for distribution to VA health-care facilities. VA uses depots primarily for products that have a long shelf-life and are widely utilized by VA health-care facilities. Depot prices for most drugs and biologicals historically have been even lower than FSS prices, because VA, rather than the manufacturer, bears the cost of distributing a drug or biological through the depot system. DoD and PHS also operate depots through which they purchase and store drugs and biologicals at prices comparable to those charged to VA for drugs and biologicals distributed through VA depots.

day before the Medicaid outpatient prescription drug rebate program went into effect. In response to VA and DoD's need to stockpile drugs and biologicals to treat potential casualties of Operation Desert Storm, most manufacturers voluntarily extended prices under expiring FSS contracts through March 31, 1991. These actions delayed dramatic increases in FSS prices for many drugs and biologicals.

While the Committee is most familiar with the impact of dramatic drug price increases on VA, the Committee has received information that DoD and PHS also have experienced serious difficulties in coping with price increases. Since both DoD and PHS purchase many drugs and biologicals through the FSS, they have encountered the same price increases as VA for those products. Also, both DoD and PHS have experienced significant increases in prices for drugs and biologicals purchased through their depots.

Since the enactment of OBRA 90, VA has made extensive efforts to control pharmaceutical costs through management initiatives. VA officials have negotiated depot and single-award contracts—which are exempt from Medicaid best-price rebate calculations under OBRA 90—for several drugs and biologicals previously purchased solely through the FSS. Individual VAMCs have instituted more rigid controls over physicians' prescribing practices, mandating use of generics and therapeutic equivalents in many circumstances.

Some of these actions constitute prudent and appropriate efforts to manage scarce resources. Others raise questions about the ability of individual VA medical centers to furnish high-quality health-care services under post-OBRA 90 budget constraints. The Committee knows of at least two VA medical centers that attempted to control pharmaceutical costs by substituting a less expensive combination drug for certain high-cost drugs used to treat hypertension. Not only has this combination drug been found to be less effective, it also is known to produce more serious side effects that may discourage patient compliance with the regimen that the physician prescribes. Also, at least one VA medical center has limited the number of patients receiving kidney dialysis due to the high cost of erythropoietin, a genetically-engineered drug used to treat the anemia brought about by kidney dialysis and other medical treatments. In addition, the Committee knows of several VA facilities that allowed their inventory of some pharmaceuticals to be depleted at the end of fiscal year 1991. Such practices are clearly unacceptable.

The impact of drug price increases on VA is not confined to its pharmacies. Many VA facilities are coping with increases in pharmaceutical costs by diverting to drug purchases funds from other aspects of their operations. Responses received by the House Committee on Veterans' Affairs to its 1992 survey of VA health-care facilities indicate that, partly as a response to the increased costs of drugs and biologicals, some VA facilities have reduced their outpatient rolls, canceled some outpatient clinics, instituted hiring freezes, and delayed maintenance projects or the procurement of needed medical equipment; other facilities are reportedly planning such actions. Such actions mean longer waiting times for scheduled appointments or loss of access to VA health-care services for the

individual veteran, fewer nurses on inpatient wards to respond to patient needs, and continued use of worn-out or out-dated medical equipment. Because reduction of discretionary workload is one of VA's most widely utilized methods for reducing expenditures, the situation is particularly serious for veterans who are eligible for, but not entitled to, the VA health-care services they have received in the past and who otherwise may not have access to such services.

The Committee notes that some pharmaceutical manufacturers have suggested that the increase in VA's costs for pharmaceuticals may be due to increased utilization of pharmaceuticals rather than increases in prices. Data on VA's utilization of pharmaceuticals indicates that this is not the case. Unlike the total number of Medicaid beneficiaries, which has increased as a result of legislation enacted as part of OBRA 90 that expanded entitlement to Medicaid, the total number of veterans receiving VA health-care services has decreased slightly since the enactment of OBRA 90. In addition, according to VA officials, although VA's outpatient pharmacy workload increased 0.1 percent during fiscal year 1991, that slight increase was offset by an 8-percent decrease in inpatient pharmacy workload during that period. Indeed VA's utilization of some high-priced pharmaceuticals appears to have decreased significantly because VA health-care facilities have substituted lower-priced generics and therapeutic equivalents.

Previous legislation

In July 1991 the Senate Appropriations Committee, concerned about the impact of increases in pharmaceutical costs on VA's medical care budget, reported a provision which, after amendment in conference, was enacted as section 519(a) of the fiscal year 1992 VA-HUD Appropriations Act, Public Law 102-139. That provision exempted FSS prices from Medicaid best-price rebate calculations through the earlier of June 30, 1992, or the enactment of legislation regarding VA prices. The intent of that legislation was to facilitate temporary reductions in FSS prices until a permanent legislative solution could be enacted.

However, according to a July 28, 1992, VA report on the impact of section 519(a), it did not produce significant reductions in VA's pharmaceutical costs. Only one pharmaceutical manufacturer provided significant reductions in prices for drugs and biologicals widely utilized by VA health-care facilities as a result of that provision. Furthermore, even though that one manufacturer did provide significant reductions in the prices charged for its products during the period that the temporary exemption was in effect, net increases in prices for some of its products remained quite dramatic—more than 600 percent over the September 1990 FSS price in one case. Moreover, since section 519(a) expired on June 30, 1992, that manufacturer and several others have discontinued selling through the FSS many of the drugs and biologicals it manufactures.

Even though these drugs and biologicals—with the exception of certain oncology agents—are available through VA depots, removing products from the FSS may still have serious consequences for VA's pharmaceutical costs. The Committee has received reports

that VA health-care facilities do not always receive shipments of drugs or biologicals from VA depots in a timely fashion. If a drug or biological is available only through VA depots, a VA health-care facility may be forced to purchase the drug or biological on the open market at a price considerably higher than the FSS or depot price. Moreover, certain drugs and biologicals having a short shelf-life are not suitable for procurement through depots.

Other manufacturers have voluntarily extended reductions in prices for certain drugs and biologicals that VA does not purchase in large quantities. Although the Committee appreciates the actions of these manufacturers, it notes that VA has no guarantee as to how long these price reductions will remain in force. Moreover, reductions in prices for drugs and biologicals that VA rarely utilizes are of little consequence for VA's total expenditures for pharmaceuticals.

Need to exempt FSS prices from Medicaid best-price rebate calculations

The Committee notes that the Committee bill is only one part, albeit a large part, of the solution required to ensure that VA and other federal agencies have access to reasonable prices. The other integral part of the solution is an exemption of FSS prices from Medicaid best-price rebate calculations. Without an exemption it will be difficult to require manufacturers to sell drugs and biologicals through the FSS in accordance with the pricing mechanisms specified in this legislation. Many manufacturers have claimed that they cannot afford to provide Medicaid, which constitutes between 13 and 15 percent of the U.S. market for pharmaceuticals, the same deep discounts they provided through FSS to VA, DoD, PHS, and Bureau of Prisons health-care facilities, which, combined, total approximately 3 percent of the market. Exempting FSS prices from Medicaid best-price rebate calculations would facilitate the restabilization of FSS prices at pre-OBRA 90 levels without forcing manufacturers to provide the same discounts to Medicaid. -

The Committee notes that any changes to the Medicaid rebate program fall under the jurisdiction of the Finance Committee. Thus, the Committee is working with Senator Lloyd Bentsen, Chairman of the Finance Committee, to develop legislation that would exempt FSS prices from Medicaid best-price rebate calculations and provide an appropriate offset for costs Medicaid may incur as a result of the exemption. One alternative would be to increase the Medicaid minimum rebate percentage by an amount sufficient to offset the estimated \$40 million cost of the FSS exemption. However, the Committee is willing to consider any other proposals developed by the Finance Committee that would yield equivalent savings for the Medicaid program.

With regard to Finance Committee action on an exemption of FSS prices from Medicaid best-price rebate calculations, Senator Bentsen stated in an August 6, 1992, letter to Senator Rockefeller,

I endorse the "two-track" approach you are taking with regard to the introduction of legislation. The use of the two-track approach will enable the Finance Committee to address the question of exempting VA prices from the

Medicaid "best price" calculation, while the Committee on Veterans' Affairs or another appropriate committee will have the opportunity to consider legislation relating to the Department of Veterans Affairs and other Federal agencies.

Senator Bentsen went on to state, "I continue to support an exemption of VA prices from the Medicaid best price calculation." The Committee notes that the Finance Committee plans to hold a markup on health-care legislation within one week of the filing of this report and that Senator Rockefeller is working with Senator Bentsen to secure Finance Committee action at that markup on legislation exempting FSS prices from Medicaid best-price rebate calculations.

The Committee expects that, as a result of such an exemption of FSS prices from the Medicaid best-price rebate mechanism, prices paid for drugs and biologicals under contracts that reference FSS prices as a basis for rebates or discounts would not be used to calculate Medicaid best-price rebates. For example, at least one State program, New York's Elderly Pharmaceutical Insurance Coverage (EPIC) program, enacted under New York Executive Laws, section 547-j (McKinney 1992), uses FSS prices as a basis for calculating rebates and discounts for drugs and biologicals dispensed to beneficiaries of its outpatient drug reimbursement program. If EPIC prices were to continue to be used as a reference for calculating Medicaid best-price rebates, the FSS price would remain the de facto Medicaid best price for those drugs and biologicals for which the FSS price is the lowest price. Such a result could undermine the Committee's goal that VA officials and manufacturers negotiate the lowest possible prices for all drugs and biologicals procured through the FSS. In order to ensure that FSS prices do not indirectly become the basis for best-price calculations, the Committee encourages the Finance Committee, in its drafting of the FSS exemption, to include a provision similar to that found in section 215 of S. 869 as passed by the Senate on November 20, 1991.

Committee bill

Legislative action clearly is needed to reverse the unintended, adverse impact of the Medicaid rebate program on VA. Deputy Secretary Anthony J. Principi articulated the scope of the problem in his testimony before the House Committee on Veterans' Affairs at its September 11, 1991, hearing on legislation dealing with this issue, H.R. 2890, as follows:

Without some relief, additional funding relief, it will mean the curtailment of some services throughout the Nation * * * outpatient care, inpatient care, longer waiting lines. Clearly, hospital directors will have to make decisions on how to manage their facilities, and without the dollars to buy the drugs, they are going to have to cut back on the delivery of health care. * * * I have spoken with enough hospital directors now whom I respect, who tell it straight to me, that we're getting hurt by this legislation and ultimately veterans are getting hurt because they're going to be denied care. That's the bottom line.

The Committee shares Deputy Secretary Principi's concerns regarding additional funding for drug and biological purchases. In its March 4, 1992, report to the Budget Committee regarding VA's budget for fiscal year 1993, the Committee recommended the appropriation of \$96 million in additional funds to offset two-thirds of the \$93 million in increased pharmaceutical costs that VA officials attributed to OBRA 90 and the additional \$30 million needed for the purchase of expensive, new bio-engineered drugs. However, neither H.R. 5679, the fiscal year 1993 VA, HUD, and Independent Agencies appropriations bill, as passed by the House nor the bill as reported by the Senate Appropriations Committee proposed the appropriation of sufficient funds to ensure that \$96 million in additional funds will be available for pharmaceutical purchases. In these times of tight budget constraints, the Committee is concerned that Congress will be unable to supplement VA's budget at the levels necessary for VA to absorb dramatic increases in prices for drugs and biologicals without further erosion of direct patient care services.

Sections 602 through 604 of the Committee bill contain three main types of provisions designed to address different aspects of the complex relationship between the pharmaceutical marketplace and VA spending. First, the legislation contains a strong mechanism to ensure that manufacturers provide discounts to the Federal Government for drugs and biologicals sold through the FSS, VA depots, and DoD depots. Second, other provisions of the legislation would establish price-discount and inflation-protection mechanisms that would provide these agencies with discounts comparable to the rebates established under the Medicaid prescription drug rebate program. Third, additional provisions would establish new purchasing mechanisms which would enable State Veterans Homes and other Federal, State, county, and municipal entities that furnish health-care services to purchase drugs and biologicals at lower cost by combining their purchases to negotiate volume discounts.

The Committee believes that the comprehensive approach embodied in this legislation constitutes the most effective means for ensuring that VA can negotiate reasonable prices for drugs and biologicals. As VA's experience under the temporary best-price exemption has demonstrated, legislation which lacks a mechanism to require manufacturers to sell to VA at reasonable prices probably will fail to achieve that goal. The pharmaceutical industry is partially immune to many of the market forces which promote price competition in other industries. There are many drugs and biologicals for which no generic or therapeutic equivalents are available. Even when similar drugs and biologicals are available, there are limits to the appropriateness of substituting one drug for another. For example, three drugs have been approved by the Food and Drug Administration for treatment of AIDS—AZT, DDC, and DDI—but neither DDC nor DDI appears to be as effective as AZT in most cases. VA, which furnishes care to approximately 7 percent of the nation's AIDS caseload, has no choice but to purchase large quantities of AZT, regardless of its cost.

The Committee notes that some manufacturers have argued that Congress need only exempt FSS prices from Medicaid best-price rebate calculations to restore VA's ability to negotiate significant

discounts for drugs and biologicals. The Committee cannot agree. VA's share of the U.S. pharmaceutical market—approximately 1 percent—is too small to provide a strong incentive for manufacturers to lower their prices to VA. Unless VA's market share is combined with that of other federally-funded health-care programs, theoretical market forces are not likely to be sufficient to ensure that VA is charged reasonable prices for, and has access to, all the drugs it needs. By requiring manufacturers wishing to sell to any federal purchaser to provide reasonable prices to all federal purchasers, the Committee bill should restore VA to the reasonable-drug-price situation it had prior to the enactment of OBRA 90. The Committee notes that the legislation would not preclude VA officials and manufacturers from negotiating discounts greater than 24 percent. Indeed, the Committee expects VA officials to strive to negotiate the lowest possible prices for all drugs and biologicals purchased by VA facilities.

Two other features of the Committee bill—the minimum-percentage-discount and the additional-price-discount mechanisms—are designed to provide VA and DoD with additional tools for obtaining reasonable prices that are comparable to the tools provided to the Medicaid program under OBRA 90.

Thus, the legislation would establish a 24-percent minimum discount (off the Federal average manufacturer price—a weighted average price for a single form and dose unit that wholesalers paid to the manufacturer) for single source and innovator multiple source drugs and biologicals. The reasons for establishing a minimum percentage discount are twofold. First, it would ensure that manufacturers will once again provide discounts for drugs and biologicals purchased through the FSS and VA depots. Prior to the enactment of OBRA 90, FSS and VA depot prices were the best or among the best prices available to any purchasers. Without a legislative remedy, such as the enactment of a minimum percent discount, there can be no guarantee that VA will once again be able to purchase drugs and biologicals through FSS and VA depots at reasonable prices. The Committee believes that the establishment of a minimum percentage discount for FSS and VA depots is consistent with the basic rebate provisions of the Medicaid rebate statute, which require manufacturers to provide rebates to Medicaid equal to the lesser of the best price available to any other purchaser or a minimum percentage discount (12.5 percent in 1992 and 15 percent thereafter).

Second, this minimum-percentage-discount mechanism would also ensure that VA receives discounts for drugs and biologicals approved since the enactment of OBRA 90. During the coming years, increasing numbers of expensive, genetically-engineered drugs are expected to be approved by FDA. For example, within the next year, the Federal Drug Administration is expected to approve a monoclonal antibody, known as HA-1A, to treat gram-negative sepsis, an infection common among patients in intensive-care units. VA officials estimate that use of this potentially life-saving drug could cost \$60 million per year. Because no therapeutic equivalents are likely to be available for many of these genetically-engineered drugs legislation should be enacted to provide VA with minimum price discounts. The Committee believes that a minimum percent-

age discount is necessary to ensure that VA and other federal agencies have access to prices for drugs and biologicals that are equal to or lower than the net prices calculated under the Medicaid rebate program.

The minimum percentage discount contained in the Committee bill reflects the Congressional Budget Office's estimate of the median percentage discount received by the Medicaid program during the first quarter of calendar year 1991 under the OBRA 90 best-price and minimum-percentage-discount mechanisms. For drugs and biologicals for which pre-OBRA 90 prices are not available for use as a benchmark, the median Medicaid discount for the first quarter of calendar year 1991 represents the closest possible approximation to pre-OBRA 90 discount levels. Since that time, the "best prices" for many drugs and biologicals have increased significantly, causing Medicaid's median percentage discount to decrease. In light of the need to stabilize FSS and depot prices at pre-OBRA 90 levels plus inflation, the Committee views the use of this percentage as most appropriate. VA pharmacy officials estimate that a 24-percent discount likely would enable VA to counter the increased costs the Department is incurring as a result of price increases that the Department has experienced since OBRA 90.

Another feature of the Committee bill, the additional price discount, is similar to a provision of the Medicaid rebate statute, the "additional rebate mechanism." The additional-price-discount mechanism would increase the minimum percentage discount for a drug or biological by an amount equal to the difference, if any, between the increase in the Federal average manufacturer price for the drug or biological and the increase in the Producer Price Index-Finished Goods during the 12 months prior to a manufacturer's entering into an FSS, VA depot, or DoD depot agreement. The net effect of the additional price discount mechanism is to contain the rate of inflation in pharmaceutical prices by providing manufacturers with a disincentive to increase their prices to VA at rates greater than the general rate of inflation.

Other provisions of the Committee bill establish specific, fixed standards for FSS, VA depot, and DoD depot prices and ensure that future increases in such prices would not exceed increases in the general rate of inflation. Some manufacturers have questioned the Committee's decision to establish such stable criteria upon which future price increases would be based. The Committee considers such criteria necessary to ensure that the Committee bill does not perpetuate a flaw of the Medicaid prescription rebate program as enacted in OBRA 90. Under OBRA 90, Medicaid's best-price rebate for a drug or biological is determined on the basis of the manufacturer's price at the time of the rebate. In order to reduce the amount of these rebates, many manufacturers have eliminated or reduced the discounts they previously provided to the FSS and certain non-federal bulk purchasers. Such actions precipitated significant increases in these purchasers' prices and may reduce the total savings Medicaid will achieve through the rebate program. Manufacturers would not have been able to do that if a benchmark had been established to serve as a basis for Medicaid best-price rebate calculations, as was proposed in the original Medicaid rebate legislation introduced by Senator Pryor and Represent-

atives Wyden and Cooper (noted above) but not included in the final OBRA 90 Medicaid rebate provisions. The Committee notes that the Department of Health and Human Services Inspector General recommended in an September 25, 1991, report that HHS submit to Congress a legislative proposal to establish a pre-OBRA 90 benchmark for Medicaid's "best prices" and restrict future increases in those prices to increases in the general rate of inflation.

Although the main thrust of title VI of the Committee bill is to ensure that VA has access to reasonable prices, it also contains provisions that would assist State Veterans Homes and other federal, State, county, and municipal health-care facilities. Sections 605 and 606 of the legislation would improve State Veterans Homes' access to discounted prices, by authorizing them to purchase drugs and biologicals at FSS prices and to participate in the Unified Pharmaceutical Award Contracts established in section 606 of the Committee bill.

Under VA's State Veterans Home program, States receive grants from VA for the construction, expansion, or remodeling of facilities that furnish long-term care services to veterans. VA also makes per diem payments to State Veterans Homes for care furnished to eligible veterans. There are currently a total of 51 State Veterans Homes operated by 34 States. Because VA does not operate a sufficient number of nursing-home and domiciliary-care facilities to meet veterans' needs for such care, State Veterans Homes are an integral and cost-effective part of the effort to meet veterans' long-term care needs.

According to the National Association of State Veterans Homes (NASVH), many State Veterans Homes have had to cope with significant drug price increases since the enactment of OBRA 90. Most are freestanding facilities that are too small to negotiate discounts for drug and biological purchases on their own. In light of the importance of the State Veterans Home program to the national effort to meet veterans' health-care needs, the Committee believes that the homes should be able to purchase drugs and biologicals at the same prices as those paid by VA health-care facilities.

Access to FSS prices should enable State Veterans Homes to reduce their expenditures for drugs and biologicals. Although the differentials between current FSS prices and State Home prices vary considerably from drug to drug, the results of a survey completed by NASVH at the Committee's request suggest that savings for some drugs and biologicals would be significant. For example, the current FSS price for a 60-tablet bottle of Zantac, the most widely-prescribed drug in the United States for treatment of ulcers and one of the drugs most frequently prescribed to State Home residents, is equivalent to \$0.71 per tablet. According to the NASVH survey, State Home prices for Zantac are considerably higher than the FSS price. The 27 State Homes that provided unit price information for Zantac pay prices ranging from \$0.89 to \$1.31.

Section 606 of the Committee bill also could benefit State Veterans Homes. That section would authorize the Secretary of Veterans Affairs to negotiate pharmaceutical contracts, referred to as unified pharmaceutical award contracts (UPACs), on behalf of VA and other federal, State, county, and municipal health-care entities that procure drugs and biologicals. The UPAC provisions are de-

signed to encourage governmental entities to utilize purchasing practices similar to those utilized by non-governmental purchasers to achieve significant price discounts. Under a UPAC, the market shares of various governmental health-care programs would be combined to form a buying group that would commit to purchasing a large quantity of a drug or biological. To prevent UPACs from imposing additional burdens on VA's budget for pharmaceuticals, the legislation would require entities participating in a UPAC to pay VA a contract user fee to offset the administrative costs of negotiating and administering a UPAC. The Committee notes that UPAC prices would be freely negotiated between the Secretary and manufacturers and, thus, would not be subject to 24-percent minimum discount that the Committee bill mandates for FSS and depot prices.

Cost

According to CBO, enactment of title VI of the Committee bill could yield savings of \$40 to \$60 million per year for VA and \$30 to \$40 million per year for DoD for drugs and biologicals purchased through the FSS. Purchases made through the FSS constitute approximately 50 percent of VA's total expenditures for drugs and biologicals. CBO has made no estimate of savings resulting from the enactment of provisions relating to prices for drugs and biologicals purchased through VA depots, which constitute for approximately 25 percent of VA's total expenditures for drugs and biologicals. CBO also estimates that enactment of title VI would yield savings in direct spending under the Medicaid program of \$30 million in budget authority and outlays in FY 1993 and \$820 million in budget authority and outlays in FYs 1993-1997. With respect to the estimated savings in the Medicaid program the Committee notes that these savings—which would, under CBO's analysis, be the result of the use of the lower FSS prices in the best price calculations—would be eliminated by legislation that the Committee expects the Finance Committee to report soon exempting the Federal Supply Schedule from Medicaid best-price rebate calculations.

TITLE VII—MISCELLANEOUS

Respite care

Section 701 of the Committee bill would make permanent VA's authority to furnish respite care to veterans eligible to receive VA hospital, nursing home, or domiciliary care.

Section 201 of Public Law 99-576, enacted on October 28, 1986, provided VA with express statutory authority to provide respite-care services to veterans eligible to receive hospital or nursing home care. Respite care, for this purpose, is defined as hospital or nursing home care which (1) is of limited duration; (2) is furnished in a VA facility on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home; and (3) is furnished for the purposes of helping the veteran to continue residing primarily at home.

The authority, initially enacted as a pilot program set to expire on September 30, 1989, was twice extended, by Public Laws 101-237

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